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PRO, risk management and liability — they may be all one



At the time of the American Medical Association House of Delegates meeting, the most soul searching, provocative discussion centered around the Professional Review Organization (PRO) and its implications and tremendous impact on medical care. If one accepts the philosophy that a physician's responsibility as a care giver, a doctor, is to help cure the sick, the ill, the infirm, then a significant dichotomy occurs. The physician since time immemorial has tried to do what is best and just for the patient. There was always a concern of finances before significant or adequate insurance existed, but somehow a middle ground of accommodation occurred and the problem was solved.

Care, one way or another, was given. Charity and bad debt were then as now a fact of life. In the early 1960s, with the advent of Medicare, more and more of the elderly who did not always have adequate or affordable insurance were guaranteed access through the largess of the federal government. There were few restrictions and even less control. The reasons for savings and thrift formerly an economic necessity became less significant. With the emergence of the age of technology and information, more expensive tests and to an extent less humanism became a reality. Unfortunately, at the same time, physicians became at risk "for treating patients." Liability for many unfortunate results, and a tort system that administering social justice instead of accessing a determination of faults, in a society run amock in its excesses, have been some of the problems impacting physicians' services. This in turn has created a crisis in the financing and delivery of medical care. No physician or any citizen in society is totally immune from the problem. Defensive medicine is alleged to cost Medicare alone 25-30% of its total patient care budget. In another even more frightening area, cesarean sections have in some areas increased to as much as 60% of all deliveries. Examples are numerous but affect every discipline.

In the last few years, in an effort to get a handle on the cost and to help control excesses, the diagnostic related groups (DRGs) were developed and placed in effect. This has to an extent helped control costs but the fallout of success has been tragic and frightful in many cases. Yet it has objectively cut down the length of hospital stay and truly has led to a streamlining of the hospital cost care complex delivery system. All of us know of excesses and abuses that necessitated the implementation of the system and yet decry the fallout and apparent callousness that can occur in isolated instances when the total patient or exigencies of family situations cannot be considered.

After DRG, the PRO became a necessary reviewing arm fortunately with a great deal of physician input. HCFA has published a number of guidelines for the PRO that concerns the practice of every single physician and doctors should be well aware of these rules. In these present PRO regulations ten different sections were utilized involving payment based on quality and denials with guidelines, annotations, reviews, languages, and model letters with gradations of substandard quality.

What is striking is the feeling engendered and the hostility emanating from the document that leaves the reviewer knowing there is no quality and all care is to one degree or another negligent, not the converse

that we do have a rather sophisticated effective health care delivery system as anyone living in America really knows. A specific letter to the patient in the denial process was to say: "Payment is being denied because the quality of the services you received does not meet the professionally recognized standards of health care."

Here in Florida this is inflammatory and leads to immediate difficulties. Implementation without appeal and without physician input has led the Association and its Board to take some forceful and affirmative action in your behalf. Two resolutions both meeting the problem head-on were acted upon at the AMA level from our state of Florida. One of them states:

PRO PROGRAMS. Whereas, Secretary Otis Bowen, M.D., Secretary of the Department of Health and Human Services, has initiated a broad reassessment of the PRO program; and

Whereas, William Roper, M.D., Administrator of the Health Care Financing Administration, has met with selected hospitals, physicians, PRO and consumer groups and has received from the American Hospital Association a list of the problems concerning the peer review process including the following:

1. Persistent high levels of review, even when the PRO has consistently failed to find any problem, resulting in both unnecessary expenditures of federal funds and increased costs for the hospital;
2. Inadequate opportunities for peer interaction during intitial denial determinations or reconsiderations;
3. Retroactive application of review criteria and policies, i.e., the application of criteria or policies to patients admitted and discharged months before the policies were issued;
4. Inappropriate denial of payment for patients whose treatment is appropriately divided between two inpatient stays, e.g., a diagnostic stay (which may be paid for) and a more expensive stay for surgery (for which payment is denied);
5. Incomplete and often confusing information being sent to beneficiaries by PROs leading to the misimpression of hospital wrongdoing; and
6. The overly narrow interpretation of administrative requirements, e.g., the requirement for hand dating of physician signatures on attestation statements; therefore be it

RESOLVED, That the American Medical Association, in conjunction with the American Hospital Association, work with appropriate federal officials in an attempt to resolve quality problems with the Peer Review Organizations (PROs); and be it further

RESOLVED, That the AMA work with the Health Care Financing Administration in revising the regulations to require a physician employed by the PRO to review all denials; and be it further

RESOLVED, That the AMA urge revision of the Health Care Financing Administration regulations to require that reconsideration of denials be done by subspecialty physician peers at the reconsideration level.

On the basis of other PRO regulations the second resolution also noted that statements prior to exhaustion of the appeal process pose great detriment to the physician/patient relationship and create a serious potential for malpractice suits. The AMA was to immediately seek modification of section 2003.2 entitled "Content of the Notice," as found in the Medicare Peer Review Organization Manual, to ensure that all appeal mechanisms available to the physician be exhausted before the beneficiary is sent a denial letter and that the language used in the letter sent by the PRO be properly worded to ensure that the patient/physician relationship is not jeopardized and that the physician is provided with the fundamental principles of fairness and due process.

More important was a meeting with the principals of Health and Human Services which occurred on December 3, 1986. Included in that meeting were William L. Roper, M.D., HCFA Administrator, Henry R. Desmarais, M.D., Executive Associate Administrator, HCFA, and Thomas Morford, Director of Health Standards and Quality Bureau. It would seem that these are pleasant, understanding and sincere people who desire to have a system that works. They are physicians or physician-oriented who regard Florida as a leader in health care and the control of excesses. They realize our problems here are multifaceted and have a profound effect on future generations of practitioners which hopefully can lead to implementation of solutions to the professional liability crisis.

In addition there have been significant meetings with the PRO. We now have a clearer understanding of the position of their Board. The PRO, by law, cannot lobby and cannot implement policy. You, my colleagues, are the only ones who can do that. More knowledge of HCFA and more public information is essential.

To deal with some of the denial issues, every hospital staff member should be intimately familiar with his own peer review team and be willing and able to impact on and form an even more effective utilization review committee. The nurse coordinator should get all information before denial is even considered. If there is adequate staff participation and a willingness to make the system work there should be no reason for denials.

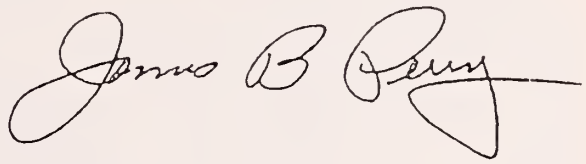
Associated with this and intimately connected with it is the risk management team. We are certain that if the professional liability problem is ever to be resolved, this in-house cooperation and effective function are paramount and essential to any solution.

The patient's individual physician can serve as an advocate of the medical profession to the hospital

and to the public. If, taking the PRO standpoint into account, a denial is necessitated, it will be based on fact without the hospital or doctor being "at risk."

In additional discussions we have agreed to hope to work out a special committee to be paid for by the PRO. It would have as advisors or members one person from each of the 13-15 specialties that impact significantly on most patients care. They will help to formulate regulations and have direct communications with HCFA in Washington to review regulations and formulate policy so that no one wil be consciously allowed to "fall between the cracks." Better worked language for denials that protect individual physicians from any taint or threat of suit and absolute immunity for all reviewers will be stronger tenets.

Ladies and gentlemen, we will make this work and we will progress to greater and more effective patient care. We need the help of every physician and the blessings of God.



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DRGs for physicians: a next step to socialized medicine

The medical profession steps into 1987 with the prospect that hospital-based physicians may soon be practicing under the DRG system. Federal health and budget officials in December had recommended bundling the services of pathologists, radiologists, and anesthesiologists into the Medicare prospective payment scheme which has been in effect in hospitals the last three years. The original proposal called for incorporating all physicians' services in hospitals with the DRG payments, but administration officials balked at the last minute and settled for a compromise plan for the hospital-based physicians after the AMA, HHS Secretary Otis Bowen, and other medical groups stenuously objected to the idea. It is now up to Congress to decide on the fate of this plan as it pores over the 1987 federal budget.

Although most physicians by now are familiar with the torrent of cost-cutting measures that has buffeted the medical profession, they were caught off guard by this latest move. Apart from the logistical difficulties that such a plan would entail, the DRG system has been widely perceived both by physicians and the public as a possible detriment to the care of the elderly and has generated a lot of unanswered questions. Prudence would have dictated that the administration proceed more cautiously in the face of an overwhelming consensus that DRGs have eroded the quality of medical care among Medicare patients.

If the DRG plan for hospitals has been a dud, the proposed scheme for physicians will be certain to be a bigger disappointment. In fact, if adopted by Congress, it may be the next logical step to socialized medicine in this country. Some physicians have pointed out there is little difference between the two systems.

DRGs may have been partially effective as a cost-cutting instrument, but that should not blind us to the potential devastating problems that they would bring to the medical profession and the public.

On top of the many strangulating regulations already in force, DRGs are certain to deal the final blow in stripping from physicians their independence and their ability to practice medicine in an atmosphere of free enterprise. Physicians at best will function as factotums or indentured servants for the government. Excellence as an ideal in medicine will be lost and mediocrity will be fostered in its place. When the government does not care about excellence, when the rewards are the same for everybody, what incentives will there be for physicians to do the best job they can? The long period of education and training that it takes to be a good physician will become meaningless in this context.

DRGs are also likely to create an administrative nightmare and mind-boggling problems related to calculating the costs of hospital and physicians' services and then dividing the spoils between the hospital and physicians. The logistics of successfully managing such a system are stupendous and can easily generate conflicts between hospitals and physicians, particularly if payments are issued to hospitals, and among physicians themselves.

But most important, DRGs carry perverse incentives for physicians to do as little as possible just as the current DRG system for hospitals has done. What is good for the pocketbook may not necessarily be good for patient care, but this is the kind of conflict that physicians will be facing under the proposed system. If physicians who admit Medicare patients to hospitals have been pressured to discharge them as quickly as possible, that pressure is likely to grow with hospital-based physicians added to the system. Either way, the potential for shortchanging patients remains strong.

The AMA as well as the involved groups of physicians have vowed to fight hard in Congress against the DRG proposal. This will be a landmark fight for medicine. It may well be its last stand against government control of the profession.

It is incumbent upon everybody to support the cause of our colleagues. Today they are on the firing line; tomorrow, it will be the rest of us.

R. G. Lacsamana, M.D.
Editor

Thoughts for the New Year

"I've shut the door on yesterday
and thrown the key away —
Tomorrow holds no fears for me,
Since I have found today."

As the old year ends and income tax returns are being prepared, and as we reevaluate our possessions and our standing in terms of material achievements and goals, so, periodically, should we reevaluate our attitudes to see that they have not grown encrusted with habits that weaken our character.

Time and space are part of the same continuum but time is indivisible, and one's every action is a blending of past experience, present situation and future expectancy. While living for the present is senseless, we must not look behind too much or ahead too far. What is necessary is a delicate combination of all three. Focusing too much on the past makes one apathetic. Peering exclusively into the future gives us unrealistic aspirations and living on a day-to-day basis prevents our learning from the past. The past is still very much a part of everything we do and though the future lies ahead, its seeds are contained in the present. To the man or woman in us, time is a quantity, to the God in us, it is a quality. Time does not belong to anyone alone, but is shared with those we love, those we work for and those we play with. Looking forward to a new year we must be willing to share our time for another's sake, else it can be as fatal to be stingy with one's time as with one's money.

Happiness in life depends upon the quality of one's thoughts. Happiness is not a station we arrive at, but a means of traveling. Life is a mixed bag of joy and sadness, laughter and tears, pain and growth. To be happy we must accept the whole package, realizing that happiness is only a part of life's puzzle. To be happy one must have something to do, someone to love, and something to hope for. One's work must provide a sense of pride and satisfaction, the use of special talents and abilities and the opportunity for recognition and contribution. To be happy we must live for something outside ourselves — another person, a cause or a belief in God. To be happy we must have hope, which is a commitment of time and energy to the future. To be happy one needs to dream, for to have no dream is to have no hope and to have no hope is to have no reason to live.

As each year goes by, one normally grows from infancy to adulthood by increasing in size, but not always in personality and character. Expected to retain child-like traits many adults remain children. Primary among these desired traits is the need for love, sensitivity, wonder, creativity, learning, exploration and spontaneity. Instead of being allowed to retain these traits, children today often are trained to outgrow them and because of this, the capacity for loving and caring may be lost, but if we relearn the ability to love we grow younger. Love is a communication by demonstrative acts to others of our concern and caring, that we will be there in time of need. At any age, one can learn to become a loving person.

The new year provides opportunities to nurture one's capacity to love and grow younger by being more caring and compassionate in relations with our neighbors, friends and colleagues. By being more forgiving, by renouncing and rejecting selfishness, greed and injustice, we prepare the way for continued growth and perfection through immortality. Caring is a natural instinct in man but it must be cultivated. It is a virtue because it finds values where none seem to exist and the more values one finds in life the more full and satisfying life becomes.

So for 1987, here's a toast to each member of the Florida Medical Association for every day of the new year:

"May you have enough happiness to keep you mellow; enough trials to keep you strong; enough sorrow to keep you human; enough hope to keep you eager; enough failure to keep you humble; enough success to keep you ambitious; enough friends to give you comfort; enough faith and courage in yourself, your profession, and your country to banish depression; enough wealth to meet your needs; enough determination to make for yourself, your family and your community each day a better day than yesterday."

Clyde M. Collins, M.D.
Contributing Editor
Jacksonville

Lessons from history — a change in positions

At the present time the entire medical scene is being inexorably altered as the federal government has embarked on an approach different from that previously followed in regard to medical care for those citizens over 65. It is a change that redirects the policy

which has existed for the past 60 years in which the main emphasis has been on providing more access to medical care for elderly citizens. This was the basic principle on which the federal government based its policy throughout the years which culminated in the Medicare Act of 1965. Seemingly, nowhere was this policy greatly influenced because of cost restraints as it wound its serpentine way through the halls of Congress from the 1920s. By the very nature of the Medicare Bill, a new policy was being enacted which would necessarily redirect a sizable portion of the federal budget. Furthermore, it was recognized by both foes and proponents that the expenditures would rise with each passing year, although there was disagreement as to how big this increase would be. With this approach warmly embraced by the government, it was established that access to medical care for a segment of the population was the number one health priority for Congress at various times over the last 60 years.

This direction had been established from the 1920s until the enactment of Medicare as various groups, mainly represented by organized labor and a democratic Congress, fought many battles with the American Medical Association. The opposition of the American Medical Association was not based on the humanitarian principle involved in the issue, but the means of which to achieve the ends. During the arguments preceding the enactment of Medicare, the AMA passed an amendment in June, 1961 at its House of Delegates meeting which clearly stated that the AMA was opposed to government intervention which would compel one segment of the population to finance a socialized program of health care for another, regardless of need. This stand by organized medicine was viewed by much of the public as a recalcitrant, self-serving policy and as a result much negative publicity was generated against the AMA. This would be used as a club against physicians as it was made to appear that they were obstructing access to medical care and using the question of finances to limit this access. The public was furious and the proponents of Medicare used this to their advantage.

When Medicare was passed in 1965, the main argument that won its case was for more access into the medical system for a segment of American society. Organized medicine argued that financing for this program would become a major obstacle to providing quality medical care in the years ahead. The argument against Medicare also included the assertion that this was an unwarranted intrusion of government into medicine, which would lead to further intervention in years to come.

From 1965 until the mid-1980s the overriding principle of the federal government in its approach to medical care continued along the same lines of guaranteed more access for citizens over 65. However, in the early 1980s there began to be a realization that more access to medical care also was more expensive. Fortuitously, the technological advances of the 1960s and the 1970s began to come in daily use by the 1980s and the cost of medical care began to skyrocket. With this rise in cost came a perceptible change on the part of the federal government that monies for health care were finite and something had to be done as the Medicare system might face the possibility of bankruptcy. Against this backdrop, a rapid procession of laws began to be passed providing for DRGs, PROs, and more stringent regulations for the reimbursement of physicians, including a freeze on fees in 1984 and now a beginning of a national fee schedule starting January 1, 1987. The attempts to limit the expenditures of health care have resulted in a "feeding frenzy" by the federal government with regulations from HCFA being delivered to the state carriers of Medicare with incomplete information in its haste to regulate medicine. An example of this is the new regulations that mandate maximum allowable charges beginning January 1, 1987. These changes are scheduled to be delivered to physicians in March of 1987 so for the first two months physicians can only estimate what their fees should be.

Interesting is the fact that in the period of 20 years the physicians and the federal government seem to have assumed the previous roles of each other with the government having as its number one priority budgetary constraints and organized medicine asking for more access to medical care for the elderly. There is no doubt that the amount of medical care and the intensity of medical care have been curtailed and will continue to be curtailed under the cost cutting provisions of the federal government. Certainly, organized medicine cannot mount much of an effective argument against some changes in the medical system, as there were abuses with overhospitalization, widely divergent fees for the same procedure, etc., but the cost constraints have gone far beyond this and threaten to reduce the amount of necessary medical care given to the elderly.

On the other hand, physicians who 20 years ago voiced concerns at the intrusion of government into the medical care system are now fighting to insure that this care is not reduced. True, some of the reasons have to be regarded as protecting physicians' interests as it does impact on fees, but there is no question that the general trend is to reduce medical care for the elderly with the overriding reason being fiscal savings for the federal government.

Ironically, the federal government is now arguing from almost the same position that organized medicine was in 1965, that there is a finite amount of monies available for medical care and this has to be distributed among priorities. Organized medicine is arguing from the former position of the federal government that to deny medical care to a segment of the population because of financial reasons is not acceptable to Americans. Both parties have recognized

that in the last 20 years there is not now and will not in the future be enough money to provide utopian medical care to everyone in this country, but that those over 65 should be provided adequate, competent medical care at an acceptable price.

Organized medicine has said that under the present change medical care will not be adequate, even though the cost savings will be accomplished. The federal government seems to be in disarray on the subject of adequate medical care by saying that the proposed changes will not compromise the quality of care, but unable to defend allegations of premature patient discharge because of Medicare regulations and decreased medical services.

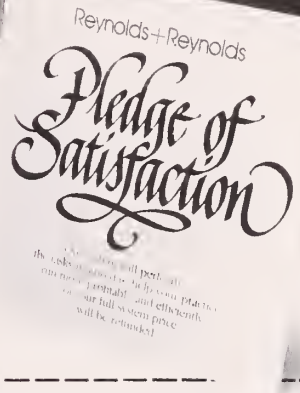
What has clearly happened is that regardless of the inability of the federal government to defend its concepts of adequate medical care with the accomplished purpose of balancing the budget, Congress, and, it appears, the judicial system of the United States have at least partially placed the burden of the question of inadequate care on the shoulders of physicians with the PROs, and the courts appear to hold physicians responsible for any medical care deemed to be inadequate, which was fostered on them with the budgetary constraints.

It is ironic that the question of adequate medical care for those over 65, and the concept of the ability of the federal government to pay for this may be subjugated to the question of why physicians are responsible for not only the quality of medical care given to the public, but also, by some contortions in logic and quantum leaps from reality, why physicians are held responsible for insuring that adequate medical care is given in the face of regulations and cost saving measures that essentially make this impossible.

H. Frank Farmer Jr., M.D. Ph.D
Historical Editor
New Smyrna Beach

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Tampa, Florida February 28 — March 3, 1987

February 28

The Neuroimaging of Stroke — II
William Kinkel, M.D.: Director

Cerebral Blood Flow Tomography with Use of SPECT
Niels A. Lassen, M.D.
Xenon Blood Flow Studies in Cerebrovascular Disease
John Sterling Meyer, M.D.
PET with NMR and CT Correlations in Cerebrovascular Disease
Abass Alavi, M.D.
Overview of NMR in Cerebrovascular Disease
William R. Kinkel, M.D.
Clinical Correlations of NMR in Cerebrovascular Disease — I
Joseph Masdeu, M.D.
Clinical Correlations of NMR in Cerebrovascular Disease — II
Peter R. Kinkel, M.D.
Panel Discussion: The Significance of the Ubiquitous Increased Signal Lesions in T2 NMR
Vladimir Hachinski, M.D.: Moderator
Welcome Reception Party (Complimentary)

Dinner Seminar: The Neuroimaging of Pediatric Neurology
Asma Fischer, M.D.: Director

Use of NMR in Investigation of Childhood Stroke
Robert J. Adams, M.D.
Neurosonology of Stroke in Infancy
Matt Frank, M.D.
Cranial Sonography of Hypoxic and Ischemic Lesions in Infants
Asma Fischer, M.D.
Possibilities and Limitation of Intracranial Pulsed Doppler in Infants and Children
H.M. Strassburg, M.D.
Intracranial and Spinal Malformation on NMR and CT
Mohammed Sarwar, M.D.

March 1

The Neuroimaging of Degenerative Disease
C. Warren Olanow, M.D.: Director

Neuroimaging of Aging and Dementia
Richard C. Holgate, M.D.
Neuroimaging of Pediatric Degenerative Disorders
Stanley J. Rothman, M.D.
Neuroimaging of Multiple Sclerosis
Lawrence Jacobs, M.D.
Neuroimaging of Parkinson's Disease
C. Warren Olanow, M.D.
PET Scan — Degenerative Disorders
Jane Tyler, M.D.
Oldendorf Award Lecture
Presidential Address:
Lawrence Jacobs, M.D.
ASN Annual Business Meeting
Free Communications
The Neuroanatomy of Neuroimaging
Norman Schnitzlein, Ph.D.
Neurosonology: Principles and Practice
William McKinney: Director
Basic Physics of Ultrasound
Fredrick Kremcau, Ph.D.
Pediatric Neurosonology
Asma Fischer, M.D.
Matt Frank, M.D.
Real Time Carotid Scanning
Roger Farber, M.D.
Doppler Carotid Scanning
William McKinney, M.D.

March 2

The Neuroimaging of Spinal Disease
Jack O. Greenberg, M.D.: Director
Anatomy of Spine
Norman Schnitzlein, Ph.D.
Pediatric Spine
John Bisese, M.D.
CT of Spine
William Glenn, M.D.
NMR of Spine
F. Reed Murtagh, M.D.
Spinal Trauma: CT and NMR
Robert Quencer, M.D.
Intraoperative Ultrasound of the Spine
Robert Quencer, M.D.
McKinney Award Lecture
NRM: Basic Principles and Practice
William Oldendorf, M.D.: Director
NMR Basic Principles and Technology
William Oldendorf, M.D.
Clinical Application of NMR Imaging
Mark Winkler, M.D.

Dinner Seminar: Practice Economics and Neuroimaging
Francis Kittredge, M.D.: Director

March 3

Certification Exams
CT Certification Exam
Neurosonology Certification Exam
Joseph Masdeu, M.D.: Director
William McKinney, M.D.: Director

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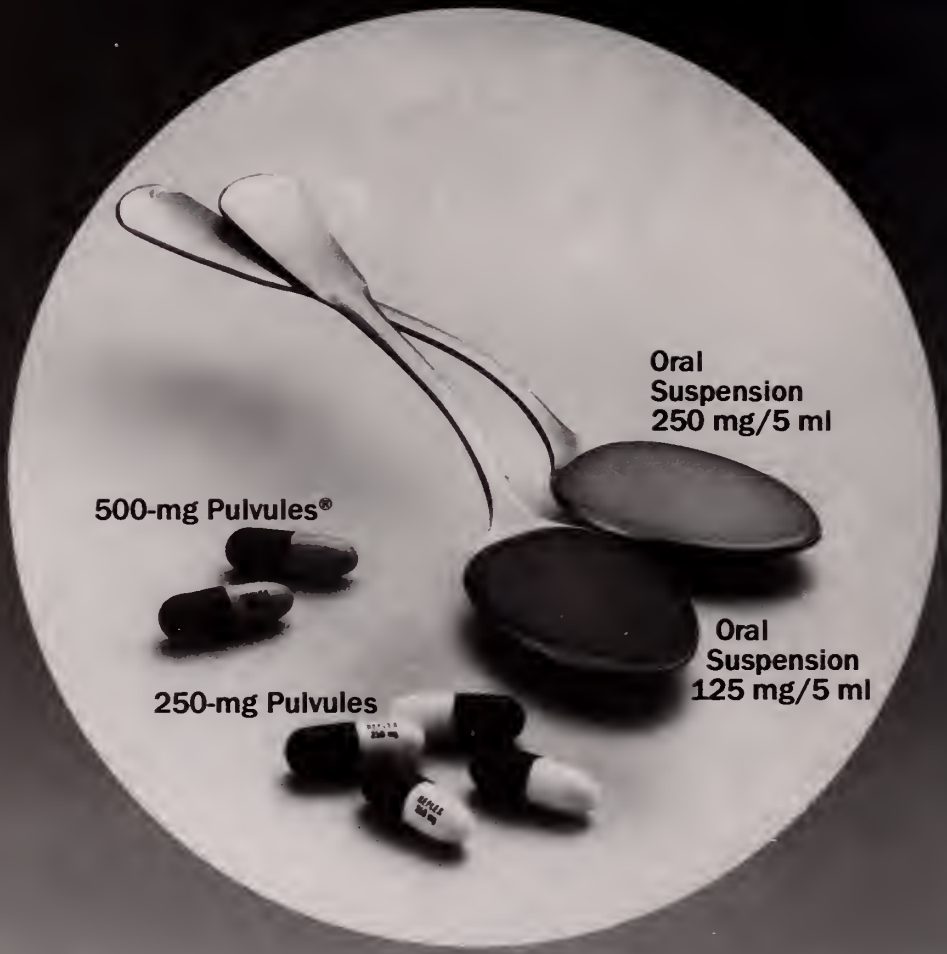
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Physicians should recognize PRO for what it is

I am writing in response to the controversy between W.E. Manry Jr., M.D., of Lake Wales and Charles B. Slonim, M.D., a member of the Board of Trustees of the State of Florida, Professional Review Organization ("In Defense of Peer Review", *The Journal*, Vol. 73, No. 9, September 1986).

It is my understanding that the Professional Foundation for Health Care of Tampa sought its contract to function as the State of Florida's Peer Review Organization aggressively. It is also my understanding that these physicians and nurses receive compensation for the "physician review" that they perform. If I am in error, I certainly would like to be corrected in my impression.

Traditionally, physicians have always represented their patients and have been advocates for their patients and their patients' causes. In a free society, physicians are compensated by their patients directly. In contrast, the veterinarian attempts to satisfy the wishes and desires of a third party. I personally view the Professional Foundation for Health Care of Tampa as concerned solely with management of "purse strings." It is contracted not by individual patients but by the Health Care Financing Administration for economic reasons.

Unfortunately, the "appeals process" referred to by Dr. Slonim as available to patients is always after the fact and retroactive. Physicians and their patients involved in acute care situations, usually in the late evening and early morning hours, must have a more appropriate "appeals process." As it stands now, prudence is often rewarded by a retroactive denial by the Peer Review Physician and a letter to the patient stating that "payment is being denied because the quality of services rendered does not meet professionally recognized standards of health care." This serves to inject an adversary position into the doctor-patient relationship by a third party.

It has been my experience as the president of a rather large medical staff, which individually reviews the fifteen to twenty denials generated at our institution each month, that care has met the accepted standards in our community and the actions of physicians appear to have been prudent and appropriate. Rarely have we felt that "the quality of service rendered does not meet professionally recognized standards of health care."

I believe that it is time for us to recognize this organization for what it in reality is rather than what it purports to be. I consider Dr. Slonim's letter to be ill conceived rhetoric to justify his egregious position with the Professional Foundation for Health Care of Tampa.

I am curious to know why a group of private physicians of Tampa became the Peer Review Organization of the State of Florida and why the Florida Medical Association has not been more directly involved in this situation.

John F. Lee, M.D.
St. Petersburg

Editor's note: The FMA applied to have the PRO contract four years ago but lost in its bid. There is an FMA committee which monitors the activities of the PRO, among other things, and will be pleased to hear and listen from physicians. Dissatisfaction with the activities of the state PRO, as the last FMA meeting had shown, is pervasive and likely will get deeper.

Mayo Clinic should see indigent patients

I would like to add my concern to those of Dr. John Morris concerning the unwillingness of the Mayo Clinic to accept patients under insurance programs.

The physicians of the Florida Mayo Clinic are allowed to practice in our state without the "annoyance" of obtaining a Florida license. This privilege is allowed through special legislation passed for their benefit, yet they refuse to accept patients enrolled in the Florida Medicaid program or other state sponsored programs.

If the Mayo physicians do not wish to join the rest of us in the care of our underprivileged, perhaps our lawmakers, with encouragement from the FMA, might consider an addition to this special legislation to require participation in state programs.

William T. Cobb, M.D.
St. Petersburg

Machiavelli and medicine: a bad mixture

Jacques Caldwell, M.D., recently directed attention to the merits of power-gaining tactics similar to those recommended, in 1532, by N. Machiavelli in *Il Principe (The Prince)*, in his discourse to Lorenzo the Magnificent (*The Journal*, Vol. 73, No. 10, October 1986). As detailed in the *Columbia Encyclopedia*, Machiavelli appears to have been describing an amoral and calculating tyrant who could unify the fragmented Italian State. *Il Principe* has been variously reviewed as "sincere advice, as a plea for political office . . . and as a political satire on Medici rule." However, the adjective "Machiavellian" has become a synonym for amoral cunning and for justification of power.

The medical profession certainly needs to avoid scrupulously any possible identification with "Machiavellinism."

Much better to identify with another work (to which the *Columbia Encyclopedia* refers), i.e., his discourses, in 1531, on the firt ten books of Livy. In it, Machiavelli expounded a general theory of politics and government that stressed the importance of an uncorrupted political culture and vigorous political morality.

We urge that physicians avoid the undesirable and unhappy public relations effect of coupling our professional activities with Machiavelli. Unfortunately, he is better recognized for amorality (the means justifies the end) than for vigorous political morality. We should not risk an unintended but possible linkage with amorality.

Samuel C. Bukantz, M.D.
Professor of Medicine
Division of Allergy and Immunology
Richard F. Lockey, M.D.
Professor of Medicine and Pediatrics
Director, Division of Allergy and Immunology
University of South Florida
College of Medicine
Tampa

Kudos to Dr. Caldwell

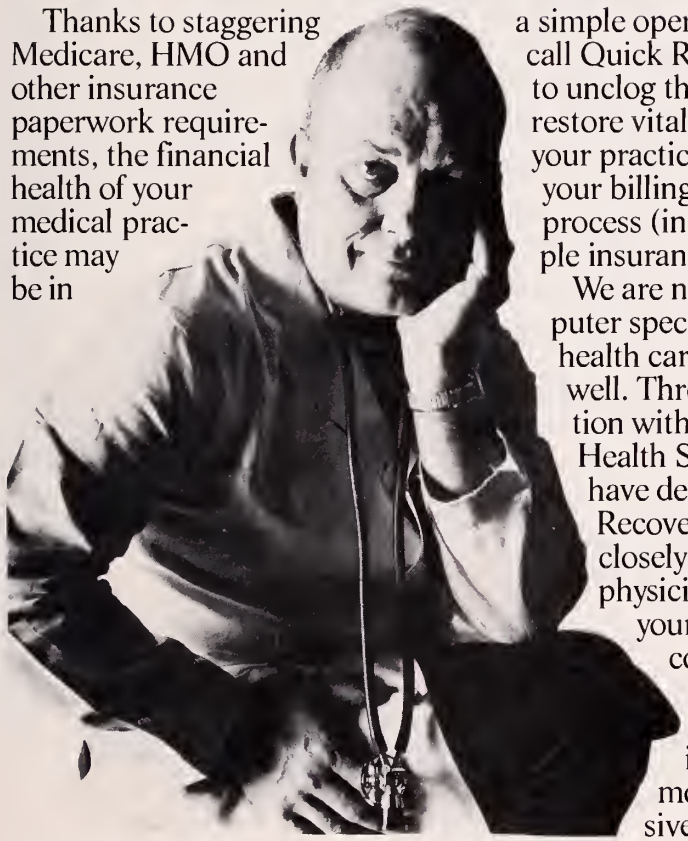
I enjoy Dr. Caldwell's assessment of the current financial turmoil in medicine and the agonies of the alphabet-soup health plans. They all seem designed to split and divide physicians in order to exert control over our destiny.

I was inspired to write after I heard President Reagan is now considering pay raises of 25% for government hierarchy. Several things bother me. One is that the AMA as a national group does not get on the attack mode but instead is back pedaling and apologizing.

I use to contribute willingly and generously to the Republican Party like many other physicians but now I encourage anyone who will listen to sign their pledge cards with "Send bill to HCFA."

Robert W. Snare, M.D.
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
JANUARY 1987, Vol. 74, No. 1

Osteoporosis screening: review of experience at a local center

Kelly Lennon, M.D.; Guy Benrubi, M.D., and Max Karrer, M.D.

ABSTRACT: A review of 103 charts of women who visited a commmunity based osteoporosis screening center was conducted to determine if photon absorptiometry techniques were more sensitive than routine clinical methods in identifying developing osteopenia. Average age of the women was 58.6 years; 29% were perimenopausal, 59% postmenopausal, and menopause status could not be clearly identified in 12%. Osteopenia was shown in 57% of the perimenopausal group, 81% of the postmenopausal group, and 93% of the unknown menopausal status group. All severely osteopenic individuals were identified as clinically osteoporotic by the referring physician. However, in cases of less pronounced bone mineral loss, photon absorptiometry identified more women than did clinical evaluation. Therefore the technique appears to be a useful aid in identifying women at risk for osteoporosis.

The Authors
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GUY BENRUBI, M.D.
MAX KARRER, M.D.
Dr. Lennon is Resident and Dr. Benrubi is Assistant Professor at University Hospital of Jacksonville, while Dr. Karrer is Attending Gynecologist at Memorial Medical Center, Jacksonville.

Osteoporosis is a progressive disease which contributes significantly to the national health care bill and individual morbidity. Ability to identify women at risk has been aided by recent advances in noninvasive diagnostic techniques. Once significant bone loss has occurred, the loss cannot be reversed.[1,2] The burden is upon the physician to identify individuals at risk and implement therapy to prevent disease progression.[3,4]

The fastest growing segment of the population in industrialized nations is the group over 75 years of age.[5] Osteoporosis occurs earlier in women than men and is significantly more common in whites than blacks. The population of the United States included an estimated 40 million women over 50 years of age in 1981. The average woman will live at least 30 years following the menopause.[4] This information, coupled with the fact that women lose 1% to 2% of bone mass per year following loss of gonadal function, highlights the impact of this disease.[6] Nearly one million fractures are sustained annually by women over 45 years of age, of which 150,000 to 200,000 are femoral neck fractures; 70% are the result of osteoporosis.[7] Interestingly, 25% of white women over age 60 have evidence of osteoporotic spinal fractures.[7] By age 90, 20% of white women will have fractured a hip; 16% of those will succumb within three months of such an injury.[7] Although femoral neck fractures accounted for only 2% of all fractures in one area study, these injuries accounted for a disproportionate segment of health care services, including 56% of physical therapy and 52% of hospital bed days for all patients with fractures.[8] The current cost expenditure is $3.8 billion a year, excluding the costs of long-term supportive therapy.[8]

Although no agreement on optimal prophylactic regimen exists, clearly osteoporosis can be prevented,

Table 1. — Comparison of Mean Age and Presence of Osteopenia Between Perimenopausal, Postmenopausal, and Unknown Menopausal Status Groups.

Group	No.	Mean Age	Osteopenia Total No.(%)	Severe(%)
I Perimenopausal	30	49.1	17(57)	1(3)
II Postmenopausal	59	63.5	48(81)	23(38)
Surgical	17	—	16(94)	6(35)
Natural	42	—	32(76)	17(40)
III Unknown Menopausal Status	14	60.8	13(93)	7(50)

but prophylactic therapy must be initiated prior to, or soon after, onset of menopause. Individuals recognized at risk should be screened to determine progression of this disease. Recent advances in diagnostic techniques make examination of bone mineral content both safe and affordable. Screening programs have been established to identify women at risk of fractures. The purpose of this investigation is to determine if the use of photon absorptiometry techniques at a recently established osteoporosis screening center in Jacksonville, Florida, are more sensitive than routine clinical methods in identifying developing osteopenia.

Materials and methods • Records of 103 women who visited the Northeast Florida Osteoporosis Diagnostic Center (NEFODC) from January 24, 1984 to February 4, 1986, were reviewed. The NEFODC was established in 1983 as a referral center for the screening, identifying, and caring for women at risk of osteoporosis within the community. Each individual who visited the NEFODC underwent a personal history interview of age, height, weight, and pertinent medical information with attention to risk factors. Additionally, women had dietary evaluation to determine average daily calcium intake. Photon absorptiometry was performed of appendicular and/or axial bone. Single photon absorptiometry was performed on the dominant wrist (radius and ulna) to evaluate appendicular or cortical bone mineral content and density. Dual photon absorptiometry was performed on four vertebral bodies of the lumbar spine to evaluate axial or trabecular bone mineral content and density. Data were reviewed by a radiologist to identify at risk factors and degree of bone mineral content and density loss compared to age-matched normals and young normals. Recommendations were then made to the referring clinicians.

Individuals studied were separated into three groups. The first group (Group I) was identified as perimenopausal and included women who were premenopausal and postmenopausal by less than three years. The second group (Group II) was comprised of those women who were postmenopausal by more than three years. Group II individuals were further identified as surgical castrates or those with a natural menopause. The third Group (Group III) included those women in whom menopause status could not be identified.

Absorptiometry data within each group were tabulated. Degree of bone mineral loss was further identified. This information was then compared to the number of individuals within each group who were identified as clinically osteoporotic by their physicians at the time of referral.

Results of these findings will be discussed with particular reference to the age of the population examined, chronologic relation to loss of gonadal function, and the role of photon absorptiometry in identifying women with significant osteopenia.

Results • A summary of observations made in the three groups can be found in Table 1. Of the 103 women visiting the NEFODC, the average age was 58.6 years. The mean age in Group I was 49.1, Group II 63.5 and Group III 60.8. Sixty-one percent of the women examined were over 55 years of age at the time of the initial examination.

Seventeen (29%) of the women in Group II underwent surgical menopause. Forty-two (71%) had experienced natural menopause. Average time from menopause for the entire group was 17.5 years. Although the menopausal status in Group III could not be identified, the mean age was postmenopausal. Summary information can be found in Table 2.

Absorptiometry evidence of osteopenia within each group is summarized in Tables 1 and 3. Group I included 30 women. Thirteen (43%) women had normal bone density, and 17 (57%) has absorptiometry evidence of osteopenia. Of the 17 affected women, 15 (50%) were mildly osteopenic, one (3%) was moderately osteopenic, and one (3%) severely osteopenic. Referring physicians had identified only four women in this group of 17 as having clinical

Table 2. — Number of Patients with Surgical vs. Natural Menopause.

Group	Mean Age	Time From Time From Menopause	Surgical(%)	Natural(%)
II Postmenopausal	63.5	17.5 years	17(29)	42(71)
III Unknown Menopausal Status	60.8	—	—	—

evidence of osteoporosis (decreasing height, dowager's hump, and multiple fractures).

Group II included 59 women. Thirteen (22%) women had normal bone density, and 48 (81%) had absorptiometry evidence of osteopenia. Of those with osteopenia, 19 (32%) had evidence of mild osteopenia, six (10%) had moderate osteopenia, and 23 (38%) had severe osteopenia. Clinical evidence of osteoporosis had been identified by the physicians of 36 of the 48 women.

Group III included 14 women. Menopausal information was unavailable because of inadequate medical history. The mean age of individuals in this group was 60.8 years. Of these 14 women, two (14%) had normal bone density, three (21%) were mildly osteopenic, two (14%) had moderate osteopenia and seven (50%) were severely affected. Clinicians identified ten of these 13 women as osteoporotic. Summary of observations comparing physician clinical examination versus photon absorptiometry evidence of osteoporosis can be seen in Table 3.

Discussion • Osteoporosis is considered to be the result of two progressive processes: (1) age-related bone loss affecting primarily cortical (appendicular) bone and (2) postmenopausal bone loss of trabecular (axial) bone. The absence of estrogen (or gonadal function) after menopause initiates rapid bone mineral loss, particularly of trabecular bone. Contributing factors that increase women's risk of osteoporosis are fair skin, white and oriental race, smoking, excessive alcohol consumption, slight build, immobilization, poor nutrition, inadequate calcium intake, various medications, and metabolic disorders.

Table 3. — Clinical Evidence of Osteopenia vs. Absorptiometry Evidence of Osteopenia.

Group	Clin. Evidence of Osteopenia (%)	Absorptiometry Evidence of Osteopenia (%)
I Perimenopausal	4(13)	17(57)
II Postmenopausal	36(61)	48(81)
III Unknown Menopausal Status	10(80)	13(93)

Although consensus on appropriate therapy for osteoporosis has not yet been established, estrogens have been demonstrated to reduce the rate of bone mineral loss in women who have lost gonadal function.[1,9,10] Estrogen replacement therapy (ERT) has been noted to reduce the incidence of hip and wrist fractures.[11,12] Once significant bone loss has occurred, ERT is not capable of replacing bone mineral mass.[1] However, women who receive estrogen and progesterone therapy within three years of the menopause have been found to have an increase in bone mass that is maintained for the duration of treatment.[10] In his review, Kanis states that response of bone mass to therapy will take five years to evaluate and longer for assessment of fracture risk.[2] Much attention has also been placed on the potential risks of endometrial cancer, breast cancer, and atherosclerotic heart disease associated with estrogen replacement therapy. However, studies of women managed with combination estrogen and progesterone therapy have demonstrated no additional risk of endometrial cancer, breast cancer, or heart disease.[13,14,15] In properly selected and followed individuals, ERT appears to be both safe and effective in preventing osteoporosis. Estrogens are contraindicated in women with estrogen-responsive tumors and thromboembolic phenomenon. In individuals with those conditions newly emerging evidence indicates a protective effect of progestogens on bone mineral density[16,17] and vasomotor symptoms.[18,19] Although the mechanisms of action are not clearly understood, progestin therapy is a plausible alternative to those individuals who are not candidates of ERT.

The mechanism of action of estrogens in the treatment or prevention of osteoporosis has not been clearly identified. No estrogen receptor has been demonstrated in bone,[20,21] a fact that leads to the assumption of an indirect action. Estrogens may increase the sensitivity of bone to parathyroid hormone, dihydroxy vitamin D_3, or calcitonin.[22,23] The administration of calcitonin to young and elderly women has demonstrated an increase in plasma calcitonin levels.[23] These findings suggest a role for calcitonin in the treatment of osteoporosis. Investigations on the use of calcitonin therapy in postmenopausal osteoporosis have demonstrated arrest of disease progression.[24,25] Salmon calcitonin is presently approved and available for treatment of

osteoporosis in the United States. Route of administration is subcutaneous injection.

Although dietary supplements of calcium alone may decrease the rate of bone loss, calcium appears to be most effective when combined with ERT. One and one-half grams daily of elemental calcium is required in the postmenopausal women to preserve bone density.[26] However, a recent study demonstrated a progressive fall in bone mineral content in postmenopausal women taking as much as 2.0 grams daily of elemental calcium.[27] Elemental calcium supplements of smaller dosages combined with ERT have been shown to preserve bone mass.[1]

The role of vitamin D and its metabolites in the pathogenesis of osteoporosis remains controversial. Malabsorption of calcium and low circulatory levels of 1,25 dihydroxy vitamin D_3 have been reported.[3] However, vitamin D supplements with elemental calcium or fluoride failed to prevent bone mineral loss in a study of 315 menopausal females.[1] In cases of known calcium malabsorption, small doses of 1,25 dihydroxy vitamin D_3 are advantageous. The physician must be alert for potential risks of hypercalcemia in these individuals.

Sodium fluoride is presently being investigated for its ability to prevent osteoporosis. However, reports of its benefits are conflicting. Substantial improvements in trabecular bone mass as well as a decrease in the evidence of vertebral crush fractures have been reported.[2,28,29] In contrast, a recent report failed to demonstrate preservation of bone mineral content when sodium fluoride is combined with vitamin D and calcium.[1] Additionally, fluoride toxicity is known to occur in the absence of adequate calcium supplementation

Any regimen used in the prevention or treatment of bone mineral loss should include a controlled exercise program.[30,31] Notelowitz suggests that a bone density sparing effect results from weight bearing exercise.[31] However, certain restrictions may significantly limit what an exercise program may include in the elderly affected individual. Women at risk should be encouraged to initiate an exercise regimen early in life to minimize bone mineral loss.

Early recognition and prevention is the only positive approach in dealing with osteoporosis. Although osteopenia may be reversible,[1,11,12,26] osteoporotic fractures are not. The average age of women who visited this center was 59 years. If the average onset of menopause in the United States is 50 years, and as much as 2% bone mineral is lost per year following the menopause,[6] this center saw women who had already lost 18% of their bone mineral content. For the menopausal women evaluated at the center, 35% of their bone mass may have already been lost by the time of initial examiniation.

Photon absorptiometry identified more women at risk of osteoporosis than the referring physicians did by clinical examination especially in the perimenopausal group. In each group studied, photon absorptiometry had no advantage over clinical examination for those individuals with severe osteopenia. However, in cases of less pronounced bone mineral loss, photon absorptiometry identified more women with mild bone mineral loss in those individuals not yet osteoporotic. Photon absorptiometry appears to be a useful aid to the clinician in identifying women at risk for osteoporosis. In order to maximize the use of photon absorptiometry, serial examinations of the perimenopausal group should be performed to monitor the rate of bone loss after initiation of appropriate therapy.

Little may be gained from initiating absorptiometry in postmenopausal females. The great majority of women who are postmenopausal and at risk of osteoporosis will undoubtedly have evidence of osteopenia. Appropriate therapy should be administered immediately. Photon absorptiometry may be helpful in determining the most appropriate therapy for these women, with serial examinations to monitor rate of bone mineral loss.

Conclusion ● The role of photon absorptiometry in preventing bone loss in women is most effective in identifying at risk women before substantial damage has occurred.

Photon absorptiometry has limited benefit in identifying postmenopausal women at risk of osteoporosis. Bone loss that has occurred cannot be reversed. Clinicians should identify postmenopausal women at risk by examination and history and initiate individualized prophylaxis therapy.

Identification of premenopausal women at risk through photon absorptiometry offers greater benefit. Appropriate therapy can be initiated in an effort to prevent or retard bone loss. The most prudent method of therapy to date includes estrogen replacement with sequential progestins, adequate calcium intake, and a regular exercise program.

A community based osteoporosis screening center can make a positive impact on this progressive disease through early detection.

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ACP/FSIM Florida Scientific Meeting

Editor's Note: The following abstracts were presented by the American College of Physicians in association with the Florida Society of Internal Medicine during the Florida Scientific Meeting, September 1986. These abstracts were the first and second place winners in six training programs. All first place winners were presented at the ACP/FMA meeting in Orlando.

The incidence of an attenuated form of congenital virilizing adrenal hyperplasia (CVAH) among women presenting with hirsutism and/or amenorrhea

Seventy-seven unselected female patients presenting with hirsutism and/or oligomenorrhea at The Florida Thyroid and Endocrine Clinic, Orlando, were screened over a 22-month period (5/84-3/86). On clinical and biochemical grounds, 50 patients were found to be "normal" (non-CVAH); 18 "heterozygous" for CVAH; and eight patients satisfied criteria for the diagnosis of an attenuated from of CVAH. One patient was found to have an adrenal carcinoma. A baseline 17-hydroxyprogesterone (17-OHP) level was drawn and was followed by IM injection of one ampule (25ug) of synthetic ACTH (Cortrosyn). Sixty minutes later, a repeat serum sample was drawn for determination of 17-OHP after stimulation with ACTH. "Normal" patients had a mean baseline 17-OHP level of 1.0 ng/ml (range 0.22-2.41); mean value after stimulation with ACTH rose to 2.30 (range 0.95-3.45). Patients in the "heterozygous" group had a mean baseline 17-OHP value of 2.31 (0.60-4.81); this rose to 4.39 (3.54-5.91) after ACTH stimulation. Finally, patients diagnosed as having an attenuated variant of CVAH demonstrated a mean baseline 17-OHP level of 6.44 (1.62-18.40) which responded to ACTH by rising to 20.69 (7.93-25.00). Other screening tests, including FSH, LH, prolactin, testosterone and DHEA-S did not appear to be helpful in discovering patients with an attenuated variant of CVAH. A comparison of clinical findings likewise showed that the diagnosis of late-onset CVAH cannot be ruled in or out on clinical grounds alone. In summary, 17-hydroxy-progesterone appears to be a useful screening parameter for patients presenting with hirsutism and/or oligomenorrhea. In particular, it appears to be the only useful biochemical test which can either establish or exclude the diagnosis of late-onset CVAH. In addition, the incidence found in this and other studies (6-10%) seems to be sufficiently high enough to warrant the routine incorporation of this test in the evaluation of hirsute and/or oligomenorrheic women.

Cliff Weldon, M.D.
H. J. Baskin, M.D.
Orlando

Pseudo-protozoal infestation of peritoneal fluid

Motile ciliated cells in peritoneal fluid are usually seen in the setting of a parasitic peritonitis which is associated with significant mortality and morbidity.

We report a case of viable ciliated human epithelial cells that could be mistaken for a protozoal organism identified in peritoneal fluid obtained by culdocentesis. These cells closely resemble previously described ciliated endocervical cells isolated from cervicovaginal smears.

Paul E. Ziajka, M.D., Ph.D.
Orlando

Efficacy of leukapheresis in a case of cardiac leukostasis syndrome

Leukemic infiltration of the heart has been recognized from autopsy studies. Leukostasis involving coronary arteries and valvular obstruction has been rarely reported. In a review of the electrocardiographic (EKG) findings of eight patients with leukostasis with various types of leukemia, Aronson described a range of findings without a distinct diagnostic pattern but often suggestive of ischemia. Use of leukapheresis to reduce rapidly leukemic cell burden to treat severe central nervous system and pulmonary symptoms of hyperviscosity and leukostasis is standard procedure in leukemics with a high blast burden. This is the first reported case of repeated leukapheresis as the only method of cytoreduction with resultant resolution of coronary leukostasis syndrome.

We report the case of a 47-year-old previously healthy obese black woman with newly diagnosed acute myelomonocytic leukemia. She had no past history of cardiac disease and no family history of cardiac disease. Her initial WBC on admission was 289,500/mm^3 (52% blasts). EKG at that time revealed sinus bradycardia, first degree atrioventricular block, T-wave inversion in I, II, III, AVF, V2-V6 and 1mm ST elevation in lead V2-V6. These changes were thought to be indicative of cardiac ischemia. Emergent leukapheresis rapidly lowered the WBC to 161,000/mm^3. Repeat EKG showed normal sinus rhythm at a rate of 83/minute with nonspecific flattening of T-waves anteriorly. Repeat leukapheresis lowered the WBC to 83,400/mm^3 with the EKG showing normal sinus rhythm with normal ST-T segment and with no evidence of ischemia. Myocardial infarction was ruled out with serial cardiac enzymes. We conclude that this patient briefly experienced cardiac ischemia associated with coronary microvascular leukostasis which was reversed with leukapheresis.

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An unusual complication of ventriculoperitoneal shunt

An unidentified white man in his 40s, with a ventriculoperitoneal shunt, was admitted after having several generalized seizures. His temperature was 101°, he responded only to painful stimuli, and he had symmetrical hyperreflexia throughout with bilateral Babinski responses present. His physical examination was otherwise normal. Peripheral WBC count was 30,400 with 77% PMNs and 12% band forms. CT scan revealed a large left frontal lobe abcess and aspiration of shunt fluid revealed polymicrobial flora on Gram stain. Fluid culture subsequently grew a mix of enteric Gram negative bacilli, enterococcus and *S. aureus*, and blood cultures grew *S. aureus*. Injection of radiographic contrast material into the shunt revealed communication with the bowel.

The patient was treated with prompt surgical shunt removal, external ventricular drainage, and intraventricular plus systemic antibiotics. Although his hospitalization was complicated, his ventricular fluid became sterile and his mental status improved. His drain was revised to a ventriculoatrial shunt and he was eventually discharged.

Bowel perforation is a rare cause of shunt infection, with less than 25 reported cases, all of them in children. This case is remarkable in that the patient is an adult and he presented with CNS dysfunction without abdominal signs or symptoms. While ventriculitis is a well-recognized sequela of shunt infection, brain abcess has not been previously described. The polymicrobial nature of the abcess led to the identification of bowel perforation by the shunt, and prompt treatment was successful.

Jay S. Herbst, M.D.
Raj B. Uttamchandani, M.D.
Miami

Muramidase nephropathy with hypokalemia associated with monocytic leukemia

A 60-year-old female presentd with newly diagnosed acute myelomonocytic leukemia (AMMoL). She had a three week history of fatigue and 15 pound weight loss. On admission she was afebrile, with normal vital signs. Exam revealed poor dentition with gum infiltration and splenomegaly. She had what appeared to be a large thrombosed external hemorrhoid. Following hemorrhoidectomy, this hemorrhoid was found to be massively infiltrated by leukemic

cells. Her Hct was 33%, WBC 108,000/cu mm with 20% PMN, 1% bands, 5% lymph, 41% monocytes, 1% metamyelocytes, 10% myelocytes, 22% monoblasts and platelets 120,000. Auer rods were seen on peripheral smear. Bone marrow aspirate with special stains confirmed AMMoL. Initial chemistries showed Na ± 136, K + 2.6, Cl 92, Co_2, 32, Mg 2.3, BUN 14, Cr 1.6, Ca 9.1, P 2.6 and uric acid 6.8. Urinalysis was within normal limits.

The patient received increasingly vigorous parenteral and enteral K ± replacement, up to 340 mEq over 24 hours, in order to maintain a serum K + of 3.5; during this time her urine K + measured 190 mEq over 24 hours. A serum muramidase was 225 ug/ml (normal limit < 15). She received induction chemotherapy and achieved remission. A repeat serum muramidase was 14 and patient was discharged with normal electrolytes on oral KCl 80 mEq/day.

Muramidase is a 15,000 mwt cationic protein found in lysosomes of mature granulocytes and monocytes. It is filtered by the kidney and completely reabsorbed in the cortical proximal tubule and presumably degraded locally. An excessive filtered load of muramidase can lead to formation of eosinophilic intracytoplasmic droplets, mitochondrial and nuclear distortion in the proximal tubule cell and overflow muramidasuria. Hypokalemia in the setting of elevated urine or serum muramidase associated with AMMoL or AMoL has been attributed to a specific muramidase nephropathy. Muggia et al in 1969 conducted balance studies in three such patients and found inappropriate kaliuresis without systemic acidosis and without evidence of excessive mineralocorticoid activity. The proposed mechanism is a salt wasting nephropathy induced by impaired proximal sodium reabsorption leading to increased distal tubular flow rate with subsequent enhanced K + secretion by the cortical collecting tubule. We conclude that this patient had severe potassium wasting due to muramidase nephrotoxicity associated with muramidasemia all of which abated with remission induction of her leukemia.

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An unusual case of rhinocerebral mucormycosis

Diabetic ketoacidosis is the most common underlying predisposing factor for rhinocerebral mucormycosis. Other associated predisposing factors include chemotherapy, organ transplantation in patients with immunosuppressant therapy, and corticosteroid therapy in patients with leukemia and lymphoma.

I am reporting the case of an anephric patient on longstanding stable chronic hemodialysis who expired from rhinocerebral mucormycosis. He was neither diabetic nor on immunosuppressant therapy. In a MedLine search from 1966 to present, it is the second such case reported and the only reported fatality.

Daniel Morris, M.D.
Tampa

Benign recurrent aseptic meningitis: Mollaret's Meningitis. A case report

Benign recurrent aseptic meningitis (Mollaret's Meningitis) is a rare entity with fewer than 50 cases reported worldwide since its description in 1944. Episodes of meningitis are recurrent, usually of less than seven days' duration, of variable intensity, and are separated by symptom-free intervals of days to years. The patient suffers no sequelae and the prognosis is excellent.

The clinical presentation includes the usual signs and symptoms of meningeal irritation. Fever and nausea or vomiting are common. CSF pleocytosis is present, elevated CSF protein and hypoglycorrachia can be seen. In addition, large monocytic cells named "Mollaret Cells" are usually found. One-half of patients have transient neurologic symptoms other than meningismus.

No effective therapy has been found to prevent or treat the recurrent episodes.

We describe the oldest patient with a case of recurrent meningitis, presenting as an idiopathic seizure disorder. Postmortem examination of affected areas failed to reveal an etiologic agent.

Paul Wallach, M.D.
Tampa

Complete remission of pure red cell aplasia after chemotherapy for breast cancer

B.A. is a 29-year-old black female who has had a history of severe anemia since age three months, and serial bone marrow examinations documenting erythroid hypoplasia, progressing to erythroid aplasia. She showed transient, minimal response to treatments including iron sulfate, folate, prednisone,

nandrolone, splenectomy and oxymethalone. She required transfusion one-two units of packed red cells per month to sustain a hemoglobin greater than seven grams per deciliter.

In 1980, repeat bone marrow examinations revealed almost total absence of red cell precursors. At that time, she was found to have T_2 N_1 M_0 breast cancer. After radical mastectomy, she received 13 courses of adjuvant CMFP chemotherapy, during which time transfusion requirements ceased and her blood counts normalized.

As of November 1985, four years after chemotherapy, her hemogram remains normal, and there is no evidence of cancer. She requires two units of whole blood phlebotomy to manage transfusion induced hemosiderosis.

There are 13 reported cases of red cell aplasia associated with a solid tumor. The onset of red cell aplasia preceded the diagnosis of a solid tumor in these cases by six weeks to three years. Remission of red cell aplasia occurred after chemotherapy in two cases. In one case of breast carcinoma, red cell aplasia responded to CMF chemotherapy, and remained in remission after two years of follow-up. The red cell aplasia in our case is essentially cured. Although suffering from red cell aplasia since birth, four years after CMF chemotherapy she continues to have adequate red cell production.

Patrick D. Bianchi, M.D.
Jacksonville

Hemoperitoneum from sigmoid serosal perforation complicating thrombotic thrombocytopenic purpura

J.C. was a 44-year-old WF admitted for dyspnea and disorientation. Exam: T 99 P 120 R 40 clear skin, bilateral rales, benign abdomen and non-focal neuro exam. WBC 10.7, HGB 10, PT/PTT 20/49, creatinine 1.5, BUN 43, liver profile normal. Chest x-ray: pulmonary edema. Sputum revealed gram positive cocci. Lumbar puncture negative except for protein of 70. She was intubated and treated with PEEP, penicillin and tobramycin for presumed pneumococcal sepsis and ARDS. The pulmonary capillary wedge pressure was 7. The coagulopathy corrected with vitamin K. Two days after admission, she became febrile to 103°, comtose, anuric and developed purpura fulminans. PT/PTT 13/40 platelet count 41,000 fibrinogen 410,000 (WNL), fibrin split products were slightly elevated. Peripheral blood film revealed 2+ schizocytes. Blood cultures negative. Thrombotic thrombocytopenic purpura was entertained, and she was treated with aspirin, dipyridamole, steroids and plasma. Skin biopsy revealed fibrin thrombi in cutaneous vessels without vasculitis consistent with TTP. Plasmapheresis resulted in dramatic improvement in mental status.

The following day, she became hypotensive with a rapidly falling hematocrit and abdominal pain and distention. There was no blood per rectum or NG tube. At laparotomy, a massive hemoperitoneum was noted with a freely bleeding sigmoid serosal perforation. Pathologic examination of the resected bowel confirmed that the mucosa remained intact.

This is the first reported case of hemoperitoneum complicating TTP. The pathogenesis of the unusual serosal arterial bleeding without intraluminal extension remains obscure, but treatment with antiplatelet agents and heparinization with plasmapheresis probably contributed.

Robert W. Paterson, M.D.
Jacksonville

Metastatic carcinoid presenting as chylous ascites, and masquerading as retractile mesenteritis

Chylous ascites is suspected when an abdominal paracentesis reveals milky fluid, and diagnosis is made when the triglyceride concentration of the fluid is higher than in simultaneously obtained plasma. Although the actual incidence of chylous ascites is not known, the poor prognosis of these patients is seen because the majority of patients with chylous ascites have an underlying malignancy, most commonly lymphomas.

We describe a 61-year-old gentleman, who presented with chylous ascites, weight loss, and retroperitoneal and adenopathy and at autopsy was found to have carcinoid of the ileum metastatic to lymph nodes, liver, lungs, and heart. This association, of carcinoid and chylous ascites, has only been described in the literature once before. Although this patient did not have the malignant carcinoid syndrome, the 24-hour urine 5-HIAA was elevated. We feel that in patients with chylous ascites, carcinoid should be included in the differential diagnosis.

Pedro Jose Greer Jr., M.D.
Mark Gelbard, M.D.
Miami

A 73-year-old man with multiple pulmonary nodules

A 73-year-old man was found to have multiple pulmonary nodules on a chest radiograph upon presentation for an evaluation of shoulder pain. A diagnostic work-up was undertaken culminating in a lung biopsy. Special stains of the specimen yielded the diagnosis of pulmonary nodular amyloidosis. Fifty-five previous cases have been reported. The case is discussed and the literature reviewed.

Lance Simkins, M.D., ACP Associate
Tampa

Plasmacytoma and peripheral neuropathy

A rare case of a 29-year-old white man with a peripheral neuropathy secondary to a plasmacytoma is presented. Bilateral lower extremity weakness prompted the patient to seek medical attention. Treatment with vitamins offered no relief. Four months later neurologic evaluation revealed an elevated CSF protein and abnormal nerve conduction studies. Prednisone therapy was initiated and the patient was referred to this medical center.

Examination showed decreased lower extremity muscle tone and bulk as well as impaired vibratory pinprick and position sensation. The upper extremities were normal. CBC, glucose, electrolytes, urinalysis, B12, folate, and ESR were normal. ANA, rheumatoid factor, cryoglobulins, and toxic metal screen were negative. The patient denied alcohol ingestion. The CSF protein was elevated and serum immunoelectrophoresis revealed an IgG spike. EMG showed a demyelinating polyneuropathy and a sural nerve biopsy was compatible with a chronic inflammatory polyneuropathy. Plasmapheresis and immunosuppressive therapy did not improve the patient's symptoms.

Eight months after treatment the patient presented with increased sensory deficits of the upper and lower extremities. An x-ray taken after a fall revealed a cystic lesion of the left acetabulum. CT of the pelvis showed a multilobulated lytic lesion with sclerotic borders. Biopsy results were consistent with a plasmacytoma. Bone marrow from a distant site was normal. The patient underwent a heterologous bone graft and subsequent radiation treatment with improvement of his symptoms. Plasmacytoma is a potentially curable cause of peripheral neuropathy and should be considered in the differential diagnosis.

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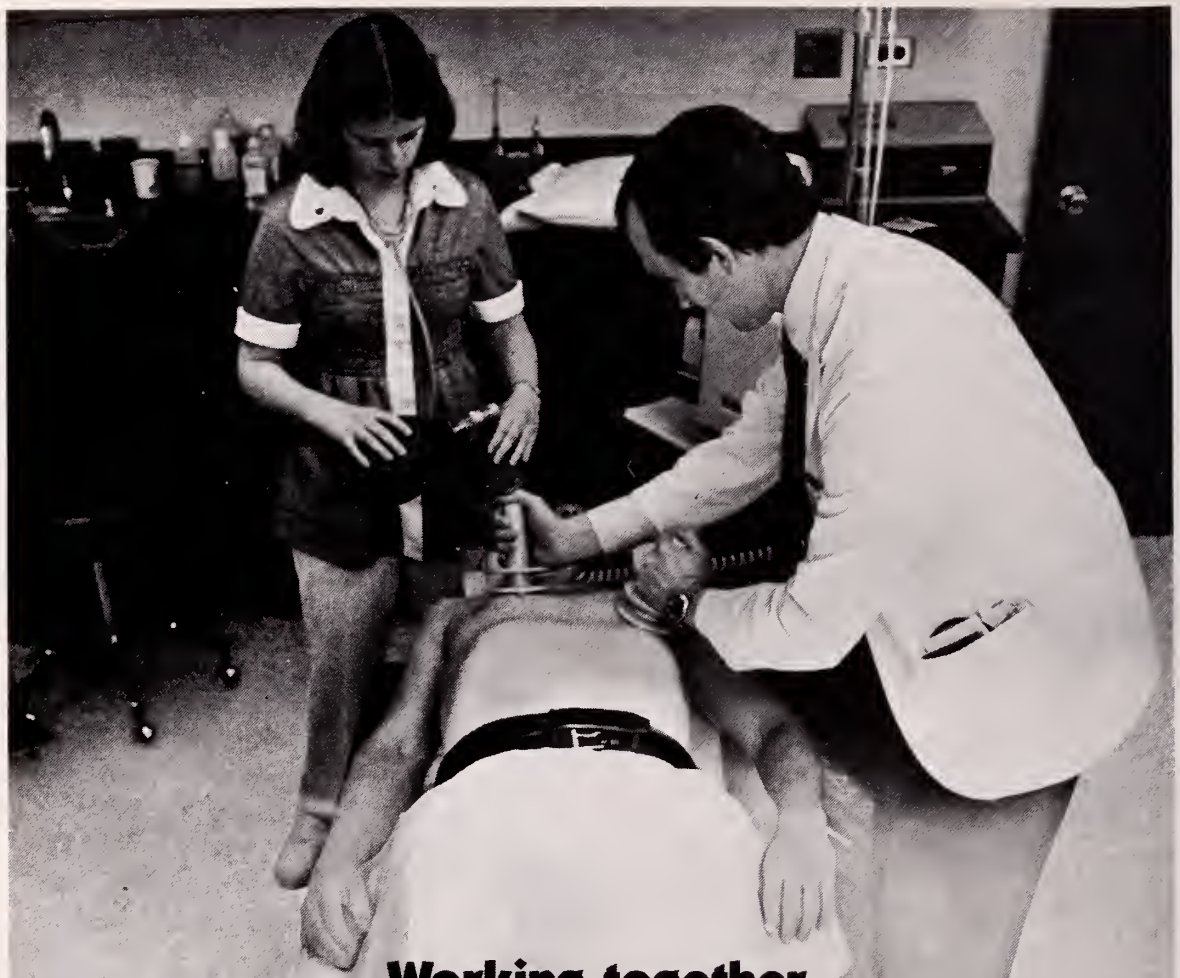
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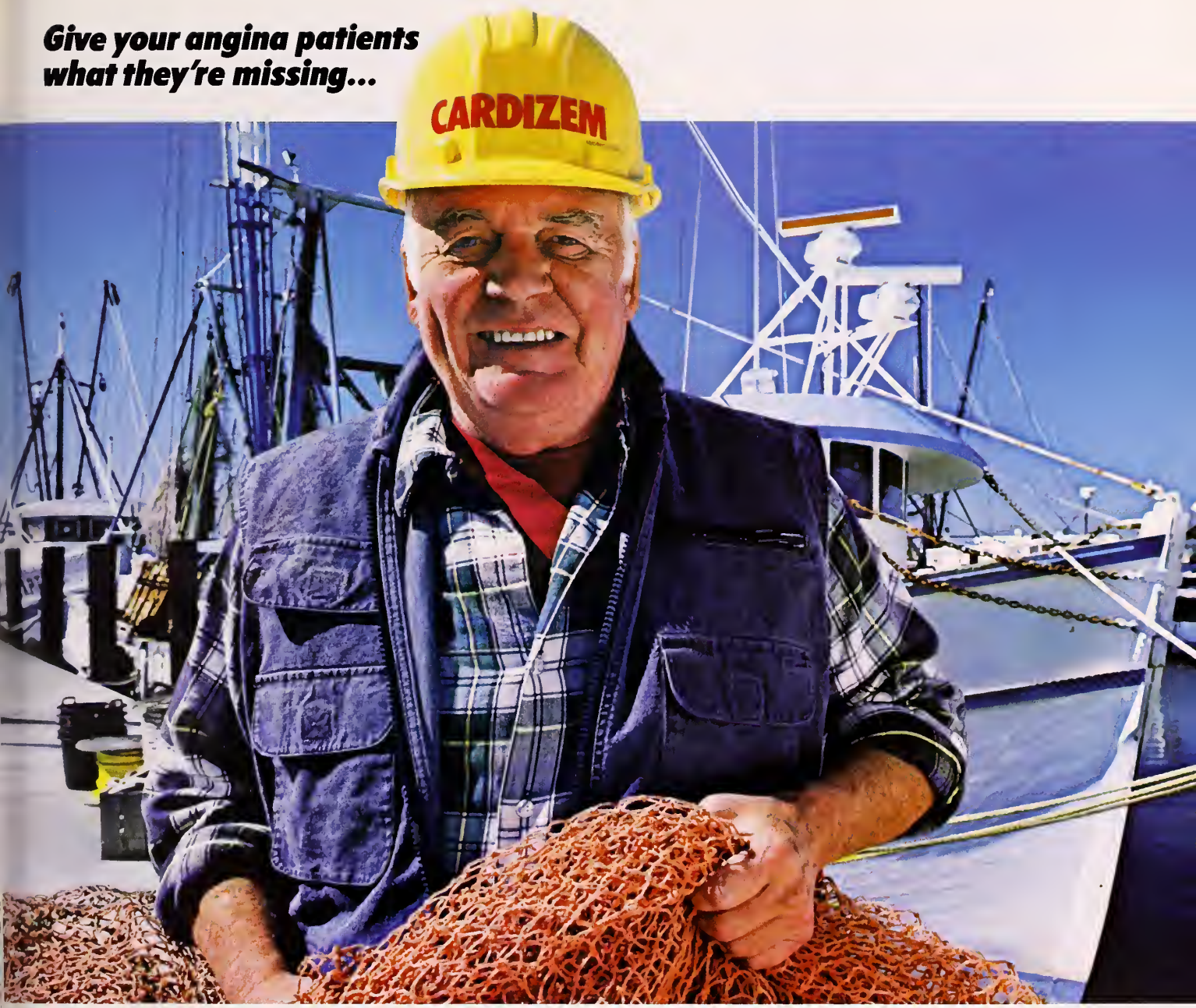
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Professional Use Information

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CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%).

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

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References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al. Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nitrendipine, and verapamil. Am Heart J 1983; 106(6):1341-1347.* ***2.*** *Shapiro W. Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984; 24(Dec):150-159.* ***3.*** *Johnston DL, Lesowyk R, Humen DP, et al. Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nitrendipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985; 55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982; 50(Sept):94-116.*

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SPECIAL ARTICLE

Continuing medical education — a professional responsibility in the public interest

William E. Jacott, M.D.

Medical education must be a lifelong process in order to maintain professional competence. The public, law makers, legal profession, and media maintain that perception. This idea, right or wrong, proven or unproven, is the basis for our system of continuing medical education and its accreditation process. Much rhetoric and many studies have been created to substantiate this perception, but we still have very little concrete evidence that continuing medical education alters practice patterns, eliminates incompetence, and improves quality.

Quoting from the Accreditation Council for Continuing Medical Education (ACCME) Essentials: "Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession." The content of continuing medical education includes knowledge and skills needed to provide health care to the public.

The preamble to the Essentials states: "The ACCME recognizes that the professional responsibility of physicians requires continuous learning throughout their careers, appropriate to the individual physician's needs." It is recognized that "physicians are responsible for choosing their own continuing medical education and evaluating their own learning achievements."

The Author
WILLIAM E. JACOTT, M.D.
Dr. Jacott is Chairman, AMA Council on Medical Education.

Public expectations • For most of this century, continuing medical education has been a voluntary academic pursuit. In response to the pressures for medical profession accountability regarding continuing competence, state medical boards implemented mandatory continuing medical education at the time of reregistration.

As mentioned, it is difficult to document a positive correlation between a physician's participation in continuing medical education and improved patient care. The justification for mandatory continuing medical education for either relicensure or recertification is difficult to establish. This represents only one marker for incompetence and must be reviewed with other factors which suggest a problem.

The public's concern is whether a physician is incompetent according to current and accepted standards. It is difficult to maintain acceptable practice standards and to seek relevant and valid methods of assessing performance in that practice. Participation in continuing medical education does not necessarily guarantee competence, but the public and many in the profession certainly believe it is important.

A review of numbers at the state level is interesting. Current AMA data indicate 12 states still require continuing medical education for medical society membership. About 23 states have some form of required continuing medical education for licensure on the books; however, three of these have not activated it. This means 20 states use continuing medical education as a requirement for relicensure — up two from last year. During a five year period (1981-86), the ACCME conducted 720 surveys for accreditation of national sponsors of continuing medical education.

Last year I identified five areas of concern:

1. Methodology in continuing medical education — individual preferences vs. state of the art.
2. Financial issues.
3. Accreditation of sponsors of continuing medical education.
4. Cooperation in continuing medical education among sponsors who issue a variety of credits.
5. Mandatory vs. voluntary continuing medical education.

Continuing medical education realities ● Let's look at some of the problems and realities that affect continuing medical education. This is not new but a review will enhance discussions later.

Factors that affect continuing medical education:

1. Advances in biomedical knowledge and technology.
2. Technology with a high degree of specialization.
3. New methods in prevention and treatment of disease that are increasingly complex, powerful, and dangerous.
4. Increased recognition that lifestyle, environment, and poverty affect health and illness as much as the health care system.
5. Higher level of public sophistication about health and special medical services.
6. Changes in practice style — solo to group. More and more physicians employed by large corporations or involved in health service organizations.
7. Influence of agencies that pay for health care — supermeds and HMOs.

Another problem is the increasing concern about abuses in the continuing medical education system. "Trust in Allah, but tie up your camel." These include the misuse of self-study materials and the designation of activities as continuing medical education when the activity is primarily developed for travel or recreation. Much of the problem deals with the misuse of joint sponsorship. Accredited sponsors of continuing medical education must accept responsibility for careful compliance with the "Essential" (especially number VII).

Let me quote from *Future Directions for Medical Education* — a document developed by the AMA Council on Medical Education and adopted by the AMA House of Delegates in 1982. "The basic problems are to devise appropriate and acceptable definitions of competence, to define criteria by which competence can be assessed, and to employ objective instruments of evaluation that provide a high degree of validity." We are still struggling with this and it represents one of our greatest challenges today. "It is clear that the relationship between education and clinical performance cannot yet be measured with scientific accuracy; however, there is consensus among physicians that continuing medical education in its various modes is a prerequisite for the competent practice of medicine."

Recommendation 29: "The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued."

Recommendation 30: "The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported."

This reminds me of what Will Rogers said, "Even though you're on the right track, you'll get run over if you just sit there."

Now I refer to an Association of American Medical Colleges report, *Physicians for the 21st Century — General Professional Education of the Physician*, often called the "GPEP Report."

Four points apply to continuing medical education:

1. "Medical education in the 20th century must prepare physicians for the 21st century who are independent learners as well as skilled technicians and caring professionals."
2. "They must be prepared to learn the fundamentals of medicine in school and through their residency, and willing to continue their education throughout their lifetime."
3. "Medicine must be learned by the student and/or physician, for only a fraction of it can be taught by the faculty."
4. "A decreased emphasis on lectures and an increased emphasis on independent learning, a skill that physicians use throughout their careers to keep up with medical science advances."

We are continually trying to prove that continuing medical education can be effective in changing physician behavior and patient outcomes. More and more papers are appearing but the results are generally discouraging. Most recently the American College of Cardiology at the Heart House Learning Center in Bethesda, Md., indicated that three fourths of attendees reported practice changes. Other papers in the last five years also confirm this but we need more studies. As one writer recently put it, "There is a serious weak link in the chain of research that is required to create new knowledge and bring it into effective use in patient care."

Accreditation process ● Now, a word about the accreditation process. The public is aware that an accredited program is important in the development of high quality presentations. It is our professional

responsibility to maintain those standards and keep the accreditation process at the high level we have all worked so hard to attain. Our review procedures must remain above turf issues, personal bias, and money matters. We need to review the checks and balances between the Accreditation Review Committee and ACCME in order to tighten areas which could lead to altered standards or worse yet litigation.

The same is true at the state level. The process must remain intact and not become a paper manuever or a coffee break procedure. The Committee for Review and Recognition is an important element and I strongly support its activities.

A few comments about quality are in order. Quality is the buzz word of the 80s. No one can clearly define it, but everyone knows what it is when they see it. The public is concerned about quality and relates physician competence and professional liability to it.

The AMA Council on Medical Service (June 1986) issued a report on "Quality of Care" which was adopted by the AMA House of Delegates. It cites three challenges posed by the health care environment:

1. "To foster a broader public understanding of what is meant by the term high quality medical care and of the current mechanisms used to assess and ensure quality."
2. "To develop guidelines regarding appropriate methods for assessing or measuring the quality of care."
3. "To encourage wide and systematic use of quality assessment findings to improve the care delivered."

These challenges can also apply to continuing medical education and deserve further study.

Some pitfalls ● I have issued several challenges. In order to meet those challenges we must be aware of certain pitfalls.

1. Realistic needs assessment that relate to medical science and knowledge and not marketing in a competitive environment.
2. Program effectiveness rather than meeting attendance as a measure of quality continuing medical education.
3. Methodology — state of art approaches including instructional television and computers rather than didactic lectures as developed in the 1930s.
4. Evaluation — still floundering here to develop realistic and practical means to assess programs and outcomes.
5. Cost — financing continuing medical education will become more difficult as less funding is available from patient care dollars.

Conclusion ● I have attempted to present the current status of continuing medical education as it relates to our responsibility in the public interest. We have looked at public expectations, continuing medical education realities, accreditation, quality and some of the pitfalls.

I believe we have the dedication and talent to overcome the pitfalls and meet the challenges. We have set our standards high — now we must maintain them.

An old proverb fits our challenge: "Take care in choosing your ambitions for in your middle age you may achieve them."

Editor's note: This paper was presented as the Keynote Address to the ACCME Fall Conference, October 9, 1986.

● Dr. Jacott, Lakeside Medical Center, 4621 E. Superior, Duluth, MN 55804.

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INFORMATION FOR AUTHORS

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Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.,* P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

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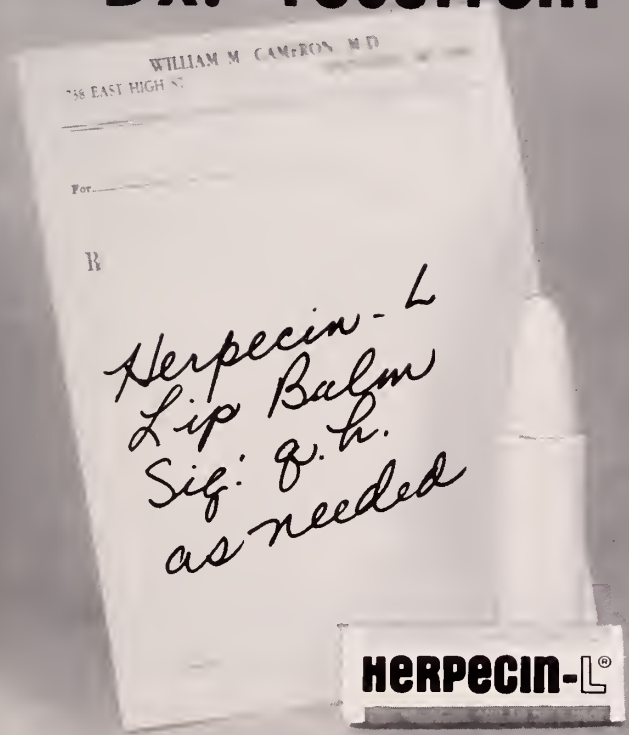
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☐ NOTES & NEWS

FMA offers new benefit programs

A number of new benefit programs FMA will be offering to its membership in the near future will include: statewide automobile leasing, a health services credit union program which includes a credit card program, a physician office products and equipment program and the AMA physician automated billing service.

The FMA-sponsored automobile leasing program will be implemented effective February 1, according to Executive Vice President Donald C. Jones. Arrangements have been made with IMMKE Circle Leasing Company of Columbus, Ohio to administer this program for FMA members.

IMMKE will open an office in Florida and make available a wide range of automobile makes and models at attractive rates and leasing arrangements under the program. IMMKE has successfully operated programs for the Ohio and Indiana State Medical Associations as well as the Professional Insurance Company of Ohio.

Complete information regarding the details of the automobile leasing program will be included in the February issue of *FMA Today*. Details of the other new benefit programs will be communicated as implementation plans are finalized.

Dr. Windom receives award

Robert E. Windom, M.D., Secretary for Health of the Department of Health and Human Services, was named the "Distinguished Internist of 1986" by the American Society of Internal Medicine at the Society's 30th Annual Meeting in September. Dr. Windom was FMA President in 1982.

Dr. Deal elected to national board of directors for AOA



William B. Deal, M.D., dean of the University of Florida College of Medicine and UF associate vice president for clinical affairs, has been elected to the national board of directors for Alpha Omega Alpha (AOA), medical honor society.

Dr. Deal will serve a three-year term on the board, which governs the activities of more than 100 chapters of AOA at medical schools across North America.

AOA is the equivalent of Phi Beta Kappa for medical schools, with only the top sixth of each class eligible for membership. The society sponsors up to 20 visiting professorships annually at medical schools.

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Volunteer Florida ophthalmologists have uncovered: 1080 cases of cataracts, 100 cases of glaucoma, 233 cases of macular degeneration, and 44 cases of diabetic retinopathy among elderly Florida residents who have called the toll-free Helpline — 1-800-222-EYES (3937) — to receive assistance through the NECP.

The public service, which offers medical eye care to the disadvantaged elderly at no out-of-pocket cost, is sponsored by the Florida Society of Ophthalmology and the Foundation of the American Academy of Ophthalmology.

The NECP is available to U.S. citizens or legal residents, age 65 or over, who are not currently under the care of an ophthalmologist, and who have not seen one within the past three years.

Since the Florida Helpline opened on March 17, more than 8173 residents have called, resulting in more than 5295 referrals of elderly patients to local volunteer eye physicians for medical examination and possible treatment for sight-threatening eye diseases.

More than 140,000 elderly Americans have called the toll-free Helpline number — 1-800-222-EYES — since the project opened in January. Amazingly, about

34% of those examined by ophthalmologists report that they had never before had a comprehensive medical eye examination. For another 20%, it had been more than five years since their last eye examination.

"We want elderly people to know that failing eyesight in their later years can be prevented or lessened through early diagnosis and treatment," said Tully C. Patrowicz, M.D., president of the Florida Society of Ophthalmology. "We are now able to repair or even replace certain parts of the eye by using sophisticated surgical tools and important new drug therapies.

Periodic medical eye examinations are particularly important, said Dr. Patrowicz, to detect potentially blinding eye disease, such as glaucoma, which has no early warning signs. Nationwide, about 1,600 cases of glaucoma have been diagnosed and treated through the project.

After calling the toll-free Helpline, an elderly person will be mailed the name of a volunteer ophthalmologist who will treat the patient, regardless of his or her ability to pay, and who will accept (for this project) Medicare or insurance assignment as payment in full. If hospital care is needed, the ophthalmologist will work with a local hospital to make care available. Hospital charges, eyeglasses and prescription drugs are not paid through the program.

More than 7,000 ophthalmologists are participating in the NECP. The Helpline is open weekdays from 8:00 a.m. to 5:00 p.m. in all states (except Hawaii, 8:00 a.m. to 3:00 p.m.).

If doctors are paid by hospitals, who will look out for medical needs of elderly?

"If both the hospital and the physician can survive economically only by doing as little as possible for patients, then who will be able to stand up for the rights of Medicare patients?" asked F. Warren Tingley, M.D., president of the American Society of Internal Medicine (ASIM), in letters sent today to key officials in the Reagan Administration and Congress. Dr. Tingley urged rejection of the Office of Management and Budget's (OMB's) proposal to include Medicare payment for physician services provided to hospitalized patients in one predetermined, lump sum paid to hospitals, which is an expansion of the current prospective payment system based on diagnosis-related groups (DRGs) now in effect for hospitals since 1983. The idea of expanding the DRG system to include physician payment has previously been dismissed by health policy advisors and researchers within and outside the Administration as being impractical, undesirable and detrimental to health care for the elderly.

A practicing internist in Arlington, Texas, Dr. Tingley pointed out that under the current system, the physician works for and is paid by the patient — and therefore has only the patient's best interests in mind. "By being paid out of the same fixed payment provided to the hospital, the physician would be under the same strong financial incentives to get the patient out of the hospital as quickly as possible or to reduce necessary services," he warned, citing studies by the AMA, ASIM and the Senate Aging Committee which show increased pressure already for physicians under the DRG hospital payment system to underprovide services and discharge patients prematurely. And, he cautioned, under such a payment system, efforts would be made to reduce the numbers of physicians who care for patients, resulting in fewer consultative and other services provided for the elderly.

Dr. Tingley also stressed that physicians who typically hospitalize patients for nonsurgical reasons would be treated unfairly by this type of payment system because these patients' conditions require resources that vary considerably from patient to patient. As a result, there is no practical way to set an appropriate fixed, average payment for these patients. In addition, he warned that such a system would most likely require mandatory assignment, which would reduce the elderly's access to medical services among other things.

"For these reasons, ASIM strongly urges the Administration (and Congress) to reject any proposal to pay for physician services through the prospective payment system for hospitals. Such a system, even if limited only to services provided by physicians in certain specialties, will inevitably compromise the quality of care provided to Medicare patients," Dr. Tingley concluded.

DEAN'S MESSAGE

Crack, concern and complications

For the past few years its has been my duty to instruct sophomore medical students in the matter of drug abuse and the consequences of irrational drug use.

The last three years I have placed special emphasis on the very real dangers related to the use of cocaine. There is little doubt that many people including medical personnel regarded the use of cocaine as a recreational activity, involving no particular danger to the user. The increased addiction liability which accompanies the pulmonary inhalation of cocaine base which results from the smoking of free base and the bicarbonate derivatives (crack) is

just now receiving the attention of the media and various governmental agencies. The enormous "rush" and the short period of action of crack lead to rapid chemical dependency.

It has been a humbling and distressing experience to learn of various surveys which indicate a substantial but hopefully episodic psychotropic drug use by medical students. In addition, as a member of the FMA Committee on Drug Abuse, I am sadly aware of drug-abuse problems which involve mature and otherwise responsible medical professionals.

This particular aspect of the problem becomes very important for the following reasons.

A recent report of the Florida Cocaine Task Force presented to the people of Florida indicates that "25 million Americans report that they have used cocaine."

"The age of initial use has declined reaching the middle and elementary schools."

"Increased availablility, decreased prices, and marketing of inexpensive quantities make cocaine (in the so-called crack form) easy to come by."

The report further states that "U.S. Customs estimates 275,000 pounds of cocaine will be brought into the country during 1986."

Thus it is entirely possible that the effects of smoking readily available and inexpensive cocaine in the so-called crack form may soon exist in an epidemic form, creating a national crisis of substantial proportions. The highly addictive effects of crack cocaine result in serious physical and psychological side effects which impede the productive activities and well being of those addicted. Furthermore, cocaine usage is not confined to the economically depressed or disenfranchised. Affluent to average economic levels of our population are major abusers of cocaine.

If, as it appears entirely possible, this problem becomes of national significance, it is clear that the medical profession will be expected to make major contributions in terms of preventive medicine and treatment modalities.

It would seem that to be truly effective those in medicine must be totally aware of the dangers of cocaine use, and most certainly be among those foremost in abstinence from drug abuse of any kind including the usage of cocaine in any form. We must be aware that new and cheaper derivatives are certain to be made available, and may well expand the user population.

It is to be sincerely hoped that our efforts as medical educators and practicing physicians will assist us in making it possible to eradicate the very destructive behavior which exemplifies the usage of cocaine by anyone.

A more meaningful educational program must be undertaken at both the medical student and house staff levels. In addition practicing physicians of all specialty groups should become well informed relative to recognition, treatment and counseling for any of their patients who abuse drugs, cocaine in particular.

There is currently a considerable body of knowledge available to us which concerns the mechanism of action of the various chemical agents of abuse, the sequele and complications of consistent abuse and withdrawal phenomena.

Parents should be educated in terms of recognition of the signs of drug abuse in children, as well as access to competent assistance and guidance for both prevention and the therapy oriented towards chemical dependency in juveniles. Physicians can be very helpful in this type of education.

Effective control and eradication of drug abuse as a major current problem will require the development and acquisition of a substantial amount of resource including funds, manpower and educational activity. Resources must be available at the national, state and local levels. Ultimate societal and political pressures may create large demands upon the medical profession to advise, assist and perhaps provide significant leadership as solutions to the problem of chemical dependence and drug abuse are sought.

There is little doubt that the medical profession will soon be required to demonstrate clearly and beyond any doubt that we ourselves do not indulge in any form of drug abuse, otherwise our concern and advice may well go unheeded.

Donn L. Smith, M.D., Ph.D.
Interim Vice President of Medical Affairs
and Dean of the College of Medicine
University of South Florida
Tampa

ENCORES!

I cannot get medical care

This is a true story told to me by a person who has requested anonymity.

I am a 25-year-old female. I have never been on welfare. I live with my mother, am not married and have no children. I am employed at a carwash and make about $450 per month. I pay my bills like everyone else and I have never had any credit problems. I live New Smyrna Beach, but have been seeing a physician in Daytona Beach for general medical problems. Recently, I began to have some pelvic discomfort which I did not think much about until it continued to persist for several weeks. I finally made an appointment with my family physician. When the doctor examined me, he told me he thought I had a

growth within my womb. He felt this was probably not a cancer, but he ordered an x-ray at a hospital in New Smyrna Beach. The x-ray was a sonogram of the uterus and ovaries. The test cost over $140, but the hospital told me that since I had no insurance and not much income I was qualified for the benefits from the Hill-Burton Act which meant I only had to pay part of the hospital bill, but was still responsible for a $70 bill from the radiologist.

I went back to my physician who discussed the case with me and confirmed that I had a growth on my uterus. This visit cost me $35, which was also the cost for the initial visit. Thus far, I has spent about $160 of my money and at this point was referred to an OB/GYN specialist in Daytona Beach. That visit cost me $60 and confirmed that I needed surgery. However, when the gynecologist found out that I did not have insurance, he told me that I could not afford to have surgery as a private patient and since I lived in New Smyrna Beach, would not qualify to have the surgery at Halifax Hospital, which was outside the taxing district of New Smyrna Beach.

At this point, I was told to contact Fish Memorial Hospital in New Smyrna Beach. I called the hospital and talked with a person who referred me to the County Health Department. I went to the OB/GYN clinic at the County Health Department and was examined by a physician. This physician confirmed what I already knew, that I had a growth on my uterus and I needed surgery. I was referred to the HRS for an evaluation to see if I could qualify for any kind of medical aid. I was told that while I was resident of the Southeastern Taxing District my hospitalization would be taken care of, but I still had to have a physician to do the surgery. The HRS worker told me I would not qualify for Medicaid because I was not married and had no children. However, I was told that I could probably qualify for food stamps. That was fine and I appreciated the stamps, but I needed surgery and I could not see where this was going to help my problem.

At this point it appeared that I was going to have to try to get the surgery myself and I went to two private physicians. Both of them quoted the price of surgery as being $1400 and both wanted at least $1000 down in order to do the surgery. One thousand four hundred dollars represents over three months of my income and I simply cannot afford it.

I do not know what I am going to do. I have a growth that appears to be getting bigger. No one is sure if this is malignant or benign at this point and I cannot afford to have surgery. I do not qualify for Medicaid. I do not qualify for Vocation Rehabilitation. Beacause I have worked, have an income, am not married and have no children I am essentially unable to have the surgery that I desperately need.

Addendum: This person was brought to the attention of Chuck Phillips, social worker at Fish Memorial Hospital who, after several telephone calls, located a gynecologist to do the surgery at no charge.

H. Frank Farmer Jr., M.D., Ph.D.
New Smyrna Beach

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Medicine and literature

William Carlos Williams, the American author and physician, once wrote, "When they ask me, as of late they frequently do, how I have for so many years continued an equal interest in medicine and the poem, I reply that they amount for me to nearly the same thing."

The interrelationship of medicine and literature is clear. Medical practice has been a rich source of material for many authors, especially physician-writers such as Sir Arthur Conan Doyle, William Carlos Williams, and Anton Chekov.

"I have no doubt that the study of medicine has had an important influence on my literary work; it has considerably enlarged the sphere of my observation, has enriched me with a knowledge the true value of which for me as a writer can only be understood by one who is himself a doctor," Chekov wrote.

The inverse — that reading literature can benefit physicians — is also true. Indeed, many literary works deal with medial subjects in a manner that can heighten the physician's sensitivity to aspects of the theory and practice of medicine.

"Because literature is free of the constraints of the day-to-day world, it is able to offer a . . . picture of . . . the world of the sick and the meaning of illness to individuals, *[a picture]* of how compassion, empathy, mercy, and other moral qualities are expressed and how they affect others," says Eric J. Cassell, of Cornell University's Department of Public Health, a well-known proponent of the humanities.

One can make a strong case for the metaphor that depicts medicine as the shoreline where the sea of science meets the land mass of the humanities. In no other area of science do traditional humanistic concerns express themselves more clearly or frequently than in medicine. In this sense, medicine and literature are "humanistic arts," and they resemble each other in their objects, effects, and aims.

The object of medicine is the study of man. Workers in medicine seek to expand the limits of our knowledge about ourselves. In the laboratory, the medical scientist uses the abstract symbols of science to pinpoint the laws governing the human organism.

At the patient's bedside, the practicing physician translates those abstract symbols to fit the case of human need before him.

Literature, too, has humanity for its object of study. The poet, using words as tools demonstrates and communicates his or her awareness of the complexity of life. Like the doctor, the poet tries to grasp, then to control, the reality of the human predicament.

The effect of medicine, when applied, is to confer pleasure by relieving pain. The poet, too, gives pleasure to those enjoying his or her art.

Finally, the aim of both disciplines is victory, however temporary, over death, the destroyer of life. Both the poet and the doctor expend extraordinary amounts of time and energy to ward of death and thus achieve immortality.

Unfortunately, even though both writer and physician struggle to create order out of the chaos of human experience, few physicians step from making diagnoses to reading literature. We would like to share a number of literary works that shed light on the following issues relevant to the physician in practice.

Professional ethics • What are the pros and cons of loyalty within the medical profession? What happens when doctors disagree about diagnosis or treatment? What is the definition of a good doctor? To what extent should a physician profit by the misfortune of his or her fellow creatures? These questions are examined closely in two works: George Bernard Shaw's play, *The Doctor's Dilemma*, exposes the physician in conflict over money and morals, and A.J. Cronin's novel, *The Citadel*, depicts a young British physician's awakening to the inequities of contemporary medical practice.

Social ethics • What is the physician's moral obligation to society and to individual patients? What happens when the physician's conscience urges a plan of action that conflicts with the law or the political establishment? These questions are explored in Henrik Ibsen's *An Enemy of the People*. This play's main character, Dr. Stockmann, clashes with city officials over public health policy. Edward Albee's play, *The Death of Bessie Smith*, portrays the fatal consequences of racism in an American hospital.

How far does "do unto others as you would have them do unto you" apply in medical practice? In research? Where do the doctor's rights end and the patient's rights begin? How should one use patients and live animals in medical research? In Sawako Ariyoshi's novel, *The Doctor's Wife*, a Japanese country physician uses family members as experimental subjects to probe his pioneering theories concerning the use of anesthesia during surgery.

The patient's prospective • Illness often causes a crisis for the patient; furthermore, this crisis and its consequences often permanently alter the sufferer's mental outlook. What changes occur in a patient's self-image due to illness? How does he or she cope with feelings of powerlessness and dependence? Denial, hostility, and regression in the patient will sometimes be followed by acceptance of illness and reassessment of values, as Leo Tolstoy illustrates in *The Death of Ivan Ilych*. Aleksandr Solzhenitsyn's novel, *Cancer Ward*, a fictionalized account of the author's own experience as a patient in a cancer hospital in the Soviet Union, dramatizes the terror and helplessness felt by the patient with a corrosive disease.

It is fortunate that only a few physicians experience severe physical or mental illness. However, fictional accounts of such diseases, viewed from the patient's perspective, can heighten the physician's awareness of and sensitivity to the precarious position of the sufferer. Graham Greene's *A Burnt-Out Case* depicts the physical and moral consequences of leprosy. Sylvia Plath's *The Bell Jar* describes the author's descent into, and subsequent recovery from psychotic depression.

Doctor-patient relationship • By virtue of being human, doctors may find it difficult to maintain a professional distance from their patients. How and when do such breakdowns in professionalism occur, and what positive or negative consequences do they have for the doctor-patient relationship? William Carlos Williams, in his short story, "The Use of Force," details the events that lead to a physical and psychological battle between doctor and patient when a pediatrician encounters a difficult child.

Perceptions of physicians • Some literary works criticize or ridicule physicians and their therapeutic endeavors, reminding us not to take ourselves too seriously. One such work is *Knock* by Jules Romains. In this play, the French country doctor is portrayed as a confidence man, who uses the gullibility of his community to build himself a position of money and power.

The physician portrayed as destroyer-of-life rather than healer is another popular image. Two obvious classics of the literature of medicine come to mind: Mary Shelley's *Frankenstein* and Robert Louis Stevenson's *Dr. Jekyll and Mr. Hyde*.

Literature raises questions about good and evil, truth and falsehood, in human behavior. For the physician, empowered with the training and the means to improve or destroy human life, a healthy dose of doubt is a necessity. The best therapy does not always lie in a rigid adherence to rules of science but may result from an assessment of the human needs of the patient. Awareness of, not indifference to, human distress characterizes the good physician. Many works of fiction heighten this awareness. The art of medicine

lies somewhere between the humanist's doubt and the scientist's certainty. Great works of literature may teach physicians to strive for perspective and sensitivity, and thus promote persons who grasp the common humanity of physician and patient.

Dr. Helle Mathiasen
Dr. Joseph S. Alpert

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Perverse incentives

With charges flying in all directions as to undertreatment in HMOs and sicker and quicker discharges in response to DRG reimbursement, perhaps a look at the relationship between reimbursement incentives and our professional integrity is in order. Is fee for service holy? Is prepayment the offspring of the devil? Or are we like the lady who agreed to sell her favors for one million dollars but balked when offered two dollars. The corruptibility had been established and after that it was just haggling over the price.

Had the medical profession been incorruptible, there never would have been the revolution we are now expericncing in the search for alternative reimbursement methods. If we had always been guided solely by the incentive to do only that which, in our best medical judgment, was required to satisfy the medical needs of our patients, we could have continued to practice unhampered by all the regulatory activities that now beset us. So many times, masterful nonintervention is better for the patient than ill conceived intervention. However, intervention is much more financially rewarding than is nonintervention. I am not so cynical as to think that the Profession has consciously sacrificed its prime incentive but reality leads me to believe that it was inevitable that medical judgment could be rationalized a bit in favor of intervention. Once started, it was also inevitable that the pace would quicken until the incentive became to earn more and more by doing more and more to more and more patients. It is not surprising to anyone involved in utilization during the past ten years, that those paying the bills finally screamed, "Stop — there must be a better way!"

However, if fee for service reimbursement created a perverse incentive to overutilize, prepayment does the opposite. If one is paid a fixed amount up front and is expected to provide all the care a patient needs for that amount, anyone can easily figure out that more money can be made by doing less. It can be argued that this is the greater hazard since patients are more likely to be injured by missing some diagnosis or cutting corners on treatment than would be harmed by performing unnecessary tests or treatments, but this is a moot topic. Our possible interventions today, even when non-invasive, are not without risk and it is still too early in prepayment history to know if the charges of undertreatment are valid, even though such perverse incentive is clearly there.

Is there then, no way to get back on track? I think so. The overwhelming majority of doctors are motivated solely by what they believe to be the best medical interests of their patients, true patient advocates, but there are enough who through greed, incompetence, laziness, or frank dishonesty so pervert the concept of good medical judgment that the credibility of the entire Profession is placed under a cloud. The aberrant few can be identified. In fact many of them are well known to third party payers already. As a Profession, we simply must recognize that they exist and we must be willing to take a stand to define and identify that behavior which is wrong and unacceptable. We have to recognize that there has been overutilization and inappropriate utilization and also that there will be underutilization and inappropriate treatment. Any reimbursement system will have perverse incentives. We must take steps to halt the errant practices. Only then will we be believed when we demand something for the good of the patient and not have it translated "for the good of my wallet."

James Conn, M.D.
Tallahassee

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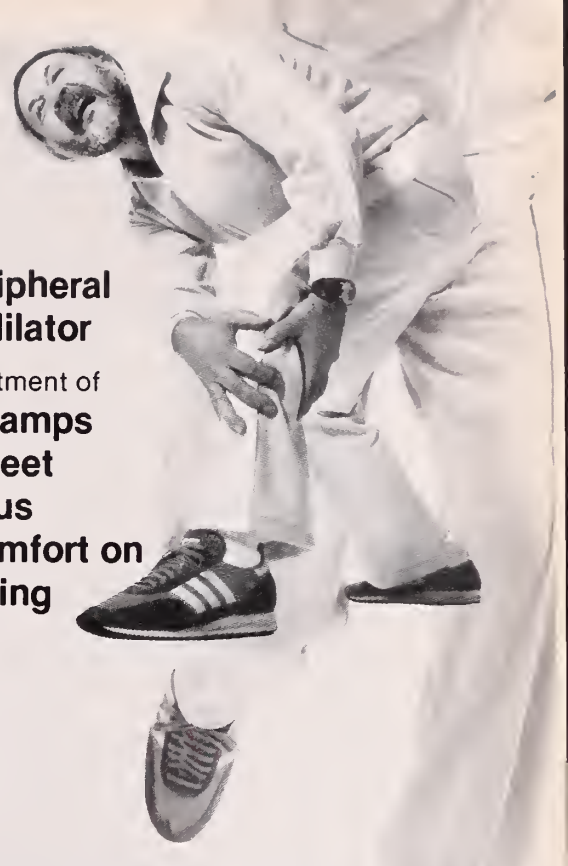
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Auxilians bank on health projects

A wealth of materials is available for health projects through the AMA Auxiliary. Each year, a new Project Bank Catalogue is sent to all county presidents from the AMA Auxiliary. The projects contained in this book are obtained from local auxiliaries throughout the nation. A brief description of these is included in the catalogue along with deposit or withdrawal sheets.

The bank is an invaluable resource for documenting and sharing auxiliary activities and for learning of the activities of other auxiliaries across the country. The Project Bank Catalogue can be compared to your favorite cookbook. It is a recipe book for health related projects. Concerned auxilians from every state who are leaders in their communities and dedicated to improving the health of all citizens have shared their innovative ideas in order to improve the quality of life in America. They have donated thousands of hours of volunteer service in this quest for excellence in health care.

A plethora of programs provides specific information on current health issues: teen suicide, child sexual abuse, drunk driving, healthy mothers, healthy babies, antismoking, fund raising, legislation, seatbelt safety, and impaired physicians. Also available free or at minimal cost are materials on estate planning, opening or closing a medical practice, and nursing recertification as an incentive for membership.

In addition, the AMA Auxiliary has a video catalogue which is available on request for auxiliary, school and community presentations on such subjects as seatbelt safety, substance abuse, drunk driving and anti-smoking.

The AMA-A brochure called "Teen Suicide" is an excellent educational tool for everyone. The brochure addresses such issues as: how to tell if a teen is suicidal; who can help in a crisis; and what concerned citizens can do. Single copies are free to AMA-A members. Additional copies are $5.00 per 100 to members and $10.00 per 100 to nonmembers. The AMA has produced three public service announcements which may be purchased for $75.00 for each 30 second segment and distributed to your local T.V. station. "No, Go, Tell" focuses on child sexual abuse. "Faces" focuses on the problems of child abuse and "Strangers" teaches a child not to talk to strangers.

Plan now for a new seatbelt program which will be available in January of 1987. The AMA-A has been selected as the prime distributor of an exciting new seatbelt program developed jointly by General Motors Corporation and the American Medical Association. This is aimed at shattering the myths about seatbelt use and encourages everyone to buckle up. The major focus of the program is pregnant women, who often do not wear seatbelts because they think that they will harm their unborn children. Infants and young children are also highlighted as a major focus of the video and accompanying materials.

Every auxiliary should take advantage of these projects. Each one is like a correspondence course geared to assisting you in planning and implementing health projects in your community.

All county health projects chairmen are asked to submit their successful projects and programs directly to the Project Bank with a copy to Bea George at 5705 S.W. 114 Terrace, Miami, FL 33156.

Bea George
FMA-A Project Bank Chairman
Miami

An Invitation from the Florida Medical Association

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Meetings

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FEBRUARY

Fourteenth Annual Seminar in Pediatric Nephrology, Feb. 1-5, Sheraton Bal Harbour, Miami Beach. Contact: Pearl Seidler, (305) 549-6726.

South Florida Winter Hand Symposium '87, Feb. 2-4, Bahia Mar Resort, Ft. Lauderdale. For more info: Jane Guterman, (305) 921-HAND.

Current Clinical Concepts in OB/GYN, Feb. 2-4, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Breznen, (305) 650-6236.

Current Practices in ECG Interpretation and Arrhythmia Management, Feb. 2-6, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

Ninth Annual Pulmonary Wintercourse, Feb. 5-8, Contemporary Hotel, Orlando. Contact: Milton Braunstein, M.D., (904) 743-2933.

Forty-third Regional Family Practice Weekend, Feb. 6-8, Sheraton St. Johns Place, Jacksonville. Contact: Annelle McClean, (904) 398-5667.

Gastroenterology Update, Feb. 7, Mt. Sinai Medical Center, Miami Beach. Contact: University of Miami, Division of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

Vail Symposium in Intensive Care, Feb. 7-14, Vail, Colorado. For more info: Sonja Craythorne, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6411.

Advances in Gene Technology, Feb. 9-13, Hyatt Regency, Miami. Contact: William J. Whelan, Dept. of Biochemistry, P.O. Box 016960, Miami 33101, (305) 547-6265.

Cardiopulmonary Rehabilitation Status '87, Feb. 10-14, University of Florida, Gainesville. Contact: Michael Pollock, Ph.D., Dept. of Medicine, Univ. of Florida, JHMHC J-277, Gainesville, 32610, (904) 392-0584.

Communicating with Patients, Feb. 12-13, Tradewinds Hotel, St. Petersburg. Contact: Daivd H. Smith, Ph.D., (813) 974-3294.

Multidisciplinary Approach to Management of Complicated Skin Infections, Feb. 12-13, Royal Plaza Hotel, Orlando. Contact: Barry Sieger, M.D., (305) 841-5144.

1987 International Disaster Management Course, Feb. 12-15, Hyatt Orlando, Orlando. For more information: Registrar, (305) 628-4800.

Pediatrics for the Practitioner: Problems in Adolescence, Bay Harbour Inn, Tampa. Contact: Herbert Pomerance, M.D., (813) 974-4214.

Pediatric Infections and Respiratory Diseases, Feb. 16-20, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

Current Topics in Occupational Medicine for Physicians, Feb. 16-20, Holiday Inn Surfside, Clearwater Beach. Contact: Continuing Medical Education, USF College of Medicine, (813) 974-4296.

Current Topics in Occupational Health, Feb. 16-21, Tampa. For more information: Nicholas Alexiou, M.D., (813) 974-3294.

Conference on the Beach, February 16-21, Daytona Hilton, Daytona Beach. Contact: Tariq Siddiqui, M.D., Halifax Hospital, P.O. Box 1990, Daytona Beach 32015, (904) 254-4167.

Eighth Annual International Gastroenterology Conference, Feb. 17-20., Peabody Hotel, Orlando. Sidhi Tewari, M.D., (305) 841-5144.

Hepatobiliary Disease in the Clinical Practice VII, February 19-21, Bal Harbour. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Bascom Palmer Eye Institute 25th Anniversary Celebration, Feb. 19-21, Fontainbleau Hotel, Miami Beach. For more information: Gaby Kressley, Dept. of Ophthalmology, P.O. Box 016960, Miami 33101, (305) 326-6031.

National Forum Aids and Chemical Dependency, Feb. 20-21, Royce Hotel, Ft. Lauderdale. Contact: Larry Siegel, M.D., (212) 206-6770.

Management of the Elderly Patient, Feb. 21-22, Sheraton Bal Harbour, Miami. Contact: Burton Goldstein, M.D., (305) 547-6716.

Chronic Pain, Feb. 23-27, Marco Island Resort, Marco Island. Albert Finestone, M.D., (215) 221-4787.

Tutorial Course in Acute Cardiac Care for the Practicing Physician, Feb. 23-28, University of Miami, Miami. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Third Annual Update on Neuro-Oncology, Feb. 24-25, Tradewinds Hotel, St. Petersburg Beach. For more info: S. Phuphanich, M.D., 12901 N. 30th St., Box 69, Tampa, 33612, (813) 974-3771.

Nineteenth Teaching Conference in Clinical Cardiology, Feb. 25-28, Sheraton Bal Harbour, Bal Harbour. Contact: Virginia McCars, Division of Research in Medical Education, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6491.

Fourth Annual Oculoplastic Cadaver Dissection Course, Feb. 26-28, USF College of Medicine, Tampa. Contact: Roger Gstalder, M.D., (813) 974-3170.

Flexible Fiberoptic Sigmoidoscopy in the Diagnosis of Colorectal Disease, Feb. 26-March 1, Wyndham Hotel, Orlando. Contact: Edward Kowalewski, M.D., (212)517-7520.

Selected Aspects of Internal Medicine, Feb. 28-March 6, Colorado, Telluride. Contact: University of Miami, Dept. of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

MARCH

Internal Medicine 1987, March 1-6, Bal Harbour, Division of CME (D23-3), University of Miami, (305) 547-6716.

Psychiatry for the Non-Psychiatric Physician, March 2-6, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215)221-4787.

Annual Medical Update Course, March 2-13, Holy Cross Hospital, Ft. Lauderdale. Contact: David E. Eifrig, M.D., (919) 966-5296.

Three-Day Diabetes Management Course, March 3-5, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

Infectious Diseases and Antibiotic Therapy '87, March 4-7, Hotel Royal Plaza, Orlando. For more information: Barry E. Seiger, M.D., (305) 841-5144.

Intensive Care for Neurological Trauma and Disease, March 4-8, Walt Disney World, Orlando. For more information: University of Miami, Division of CME (D23-3), (305) 547-6716.

Eleventh Annual Midwinter Seminar in OB/GYN, March 5-7, Don CeSar Hotel,St. Petersburg Beach. Contact: University of South Florida, (813) 974-2088.

The Heart and Brain Clinical Inter-Relationships, March 9-11, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Breznen, (305) 650-6236.

Tenth Annual Problems in Rheumatology, March 11-14, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For more information: Helen Barnwell (813) 974-2681.

Clinical Management of the Elderly Patient, March 12-14, Palace Hotel, Lake Buena Vista. Contact: Health and Education Council, (301) 686-3610.

Advances and Improvements in Hernia Surgery, March 12-14, Hyatt Regency, Miami. Contact: Arthur I. Gilbert, M.D., 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Eighteenth Annual Topics in Internal Medicine, March 12-14, Hilton Hotel, Gainesville. Contact: Craig S. Kitchens, M.D., (904) 375-6247.

Cancer Conference Daytona Beach, March 13-14, Halifax Hospital Medical Center, Daytona Beach. For more information contact: Terry Bloom, M.D., (904) 254-4210.

Critical Care Dialogues, March 14, Rusty Pelican Restaurant, Tampa. Contact: David Solomon, M.D., (813) 972-7543.

Advances in Spinal Surgery VII, March 17-22, Bal Harbour. For more info: University of Miami, Division of CME (D23-3), (305) 547-6716.

Trauma Tactics Symposium, March 20-21, Good Samaritan Hospital, West Palm Beach. For more info: Barbara L. Breznen, (305) 650-6236.

Case Study Approach to Risk Management and Malpractice, March 20 and March 28, Miami, Orlando. Contact: Gloria Allington, (305) 547-6716.

Vascular Surgery, 1987, March 22-24, Hilton Hotel, Good Samaritan Hospital. Contact: Barbara L. Breznen, (305) 650-6236.

Diagnosing Dermatology and Infectious Diseases in Pediatrics, March 23-25, Good Samaritan Hospital, West Palm Beach. For more information: Barbara L. Breznen, (305) 650-6236.

Ninth Annual Family Practice Review, March 23-27, Holiday Inn Surside, Clearwater Beach. Contact: Charles Aucremann, M.D., 701 Sixth St. South, St. Petersburg 33701, (813) 983-6156.

Internal Medicine Update '87, March 23-28, Orlando Peabody, Orlando. Contact: Barry E. Sieger, M.D., (305) 841-5144.

APRIL

Issues and Advances in Pediatrics 1987, April 2-4, Sheraton Sand Key Resort, Clearwater Beach. Contact: L.A. Barness, M.D., (813) 974-4214.

Coronary Heart Disease, April 3-4, Marco Beach Resort, Marco Island. Contact: Deborah Wilderson, (303) 798-9682.

Pediatric Oriented ACLS Provider Course, April 3-5, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Practical Aspects of Newer Cardiovascular and Renal Therapies, April 5-8, Orlando. Contact: Division of CME (D23-3), University of Miami, (305) 547-6716.

Interdisciplinary Rape Science Institute, April 5-10, Miami. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Sports Medicine and Office Orthopedics, April 6-10, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

Tutorial Course in Acute Cardiac Care for the Practicing Physician, April 6-11, University of Miami, Division of CME (D23-3), University of Miami, (305) 547-6716.

Issues in Prenatal Care — 1987, April 10-11, Indigo Lakes, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Blvd., Daytona Beach 32014, (904) 252-4701.

Advances in Magnetic Resonance Imaging, April 13-16, Palace Hotel, Orlando. Contact: Charleen Krissman, (813) 974-2538.

Coping With Stress and Anxiety, April 13-17, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

1987 Update on Diseases and Imaging of the Spine, April 17-18, Palace Hotel, Orlando. Contact: Charleen Krissman, (813) 974-2538.

Outpatient Gynecology, April 20-24, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

Second Congress on Sports Injuries for the Primary Care Physician, April 23-25, Village of Grenelife, Grenelife, FL. Contact: Brian C. Halpern, M.D., (904) 324-6661.

1987 Radiation Therapy Clinical Research Seminar, April 23-25, University Centre Hotel, Gainesville. Contact: Timothy A. Brant, M.D., Radiation Therapy Division, University of Florida, JHMHC J-385, Gainesville 32610, (904) 395-0287.

Geriatrics — Anesthesia Risks, April 24-26, Holiday Inn, Pensacola Beach. Contact: Warren W. Sears, M.D., (904) 434-4718.

Miami Comprehensive Review Course in Anesthesiology, April 25-May 2, Key Biscayne. For more information: University of Miami, Division of CME (D23-3), (305) 547-6716.

MAY

Chest Pain 1987, May 1-2, New World Landing, Pensacola. Contact: (904) 434-1093.

Radiology Review Course, May 3-8, Sheraton Bal Harbour, Miami. Contact: Lucy R. Kelley, (305) 674-2681.

Comprehensive Review and Update in Emergency Medicine, May 4-8, Hyatt Regency Westshore, Tampa. Contact: Eilleen Weimerskirch, M.D., (214) 550-0911.

Five-day Management of Diabetes Mellitus, May 11-15, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

Practical Applications in Internal and Emergency Medicine, May 25-29, Marco Island Resort, Marco Island. Contact: Albert J. Finestone, M.D., (215) 221-4787.

Master Approach to Cardiovascular Problems, May 30-June 1, Contemporary Hotel, Lake Buena Vista. Contact: Agustin Castellanos, M.D., (305) 549-7124.

JUNE

Family Practice '87, June 8-11, Hilton Hotel, Orlando. Contact: Thomas Stewart, M.D., (912) 452-2213.

Diagnosis and Management of Respiratory Disease, June 19-21, Dutch American Hotel, Orlando. Contact: Deborah Wilderson, (303) 798-9682.

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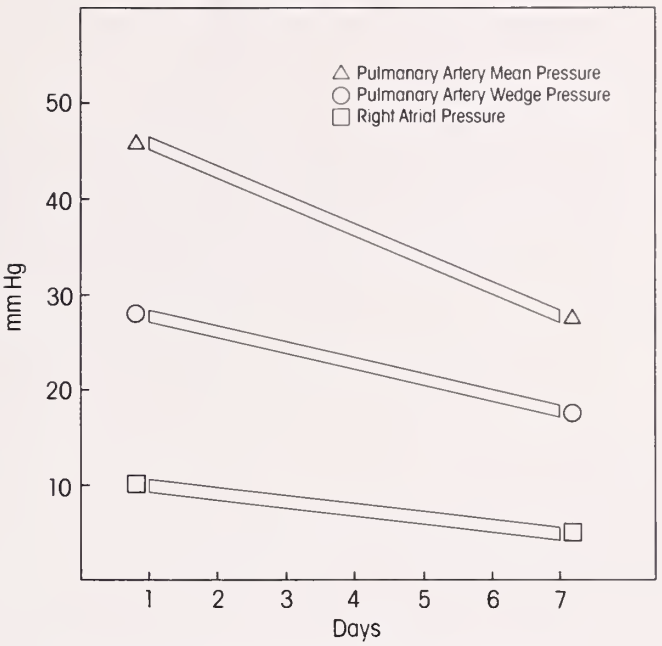
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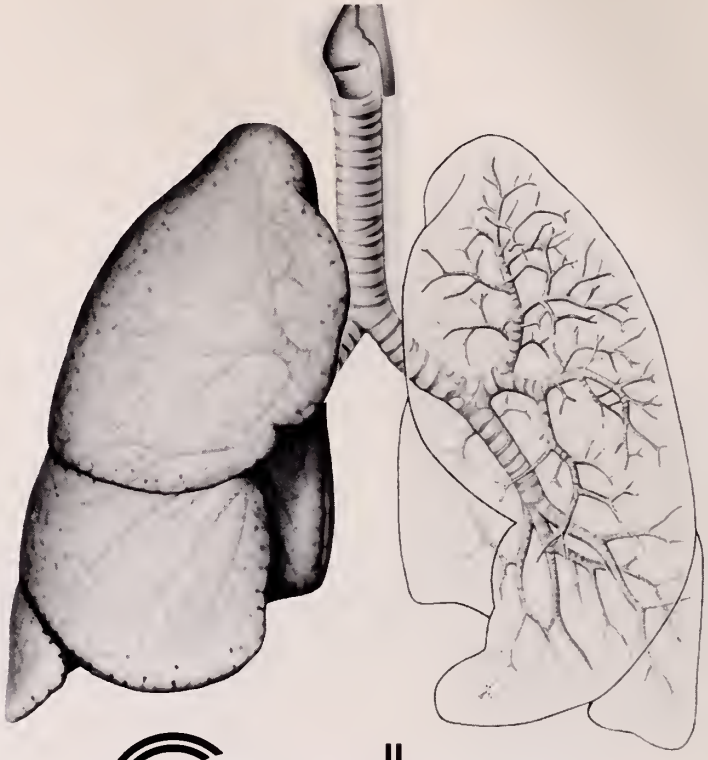
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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

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Lilly
Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285
600332
Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

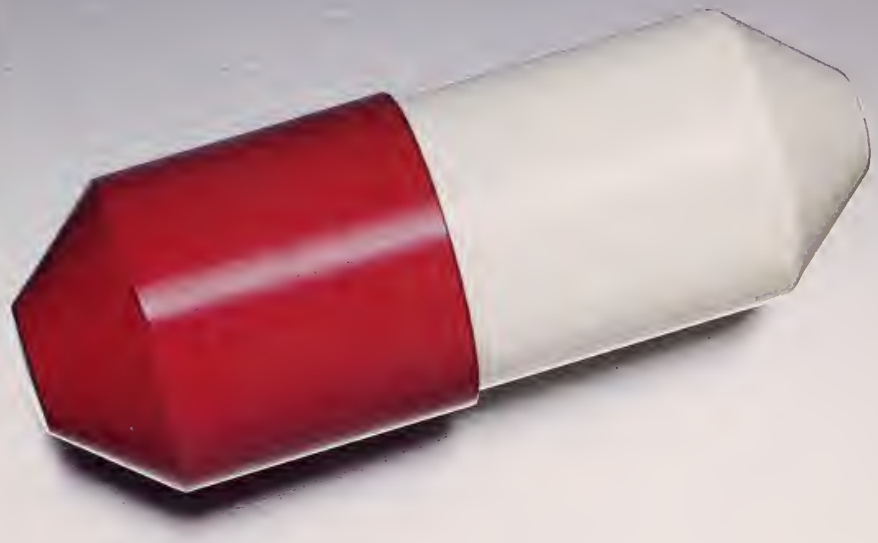
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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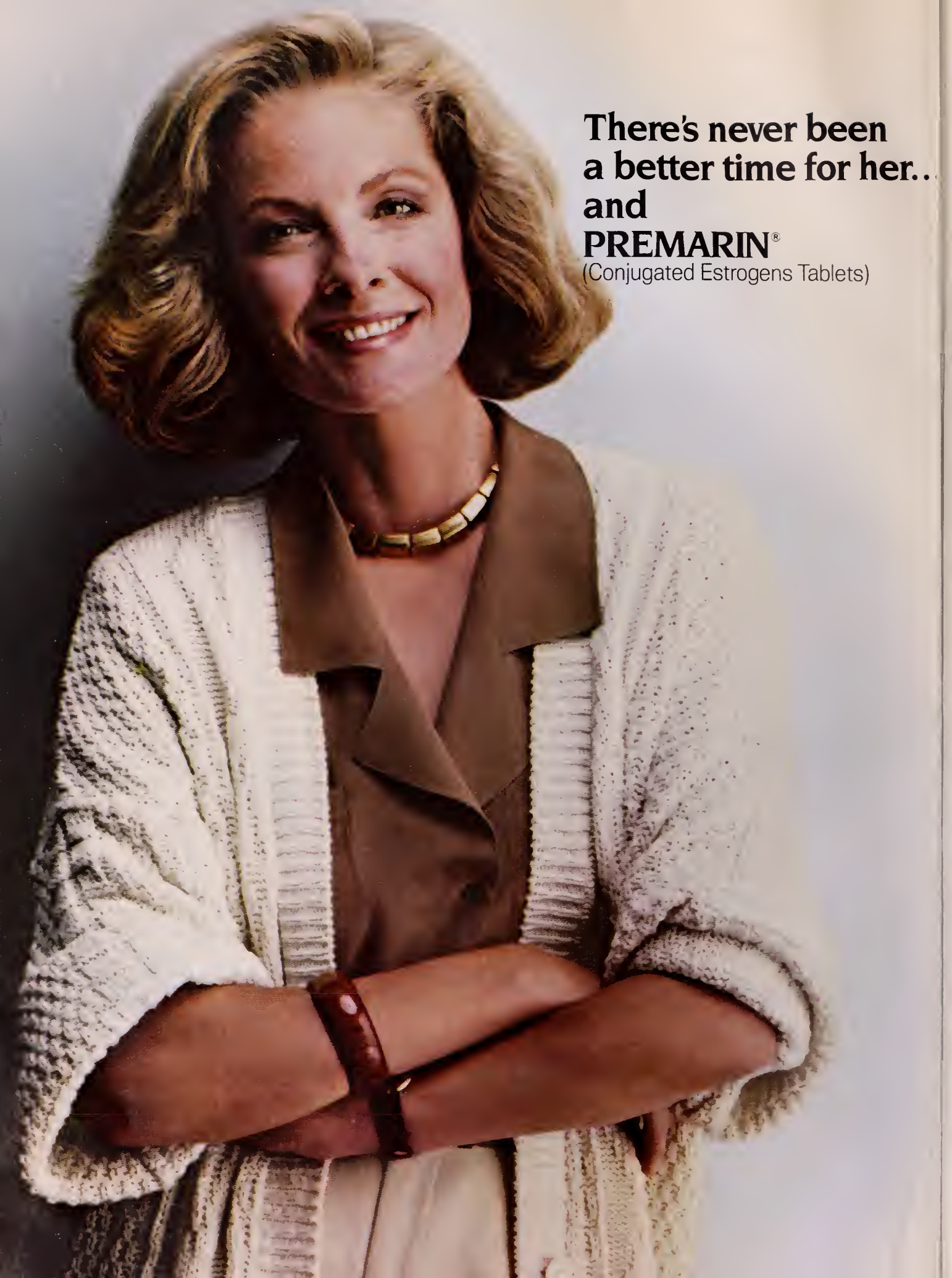
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There's never been
a better time for her..
and
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(Conjugated Estrogens Tablets)

Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®
(Conjugated Estrogens Tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®
(Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

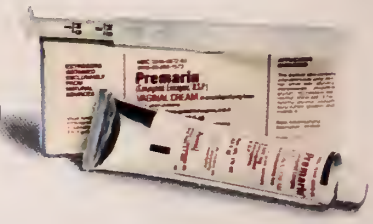
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For atrophic vaginitis

PREMARIN®
(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the fast decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important, product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea, increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema, changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

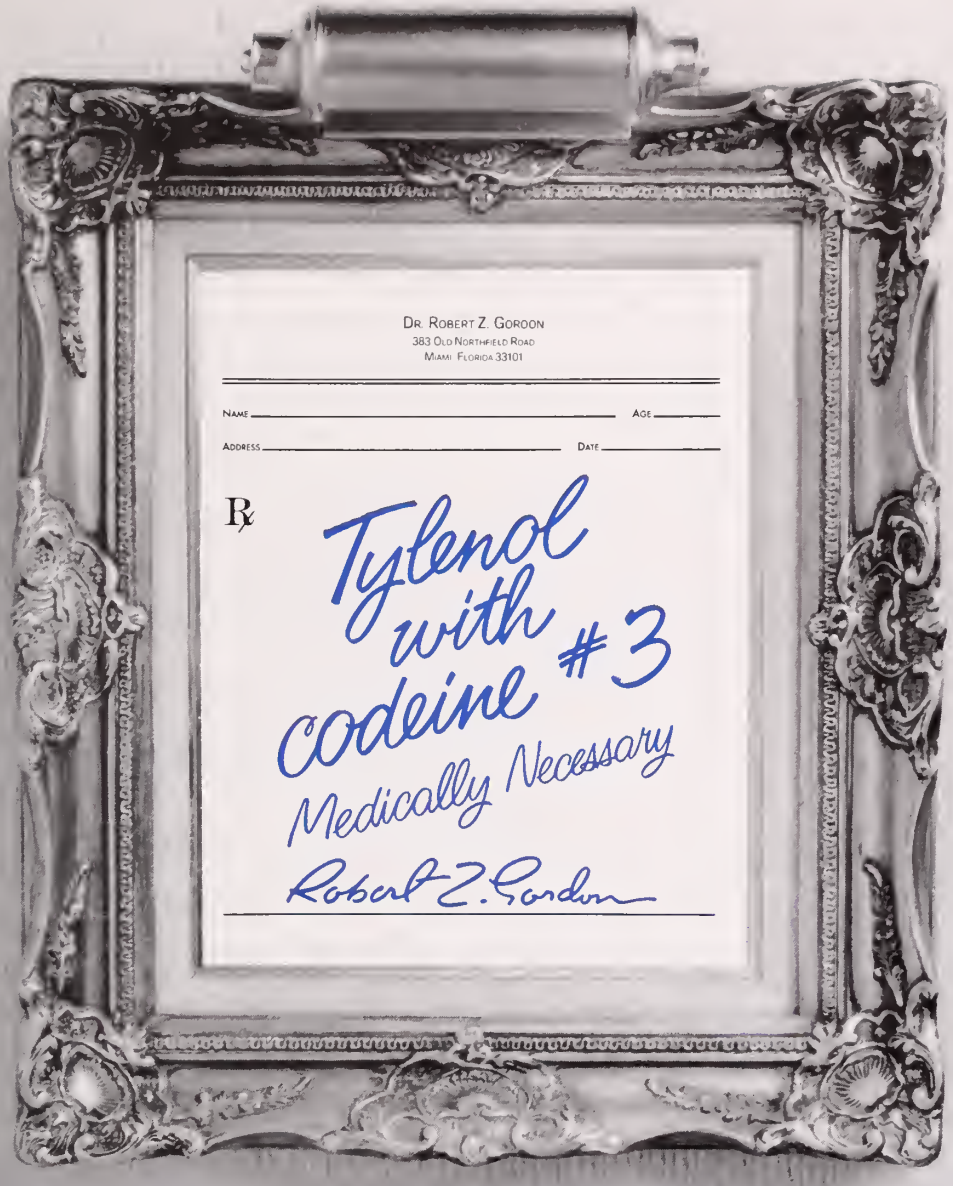
References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985;67:496-499. **4.** Whitehead MI, Lane G, Siddfe N, et al. Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

FEBRUARY 1987, Vol. 74, No. 2

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This month's cover of *The Journal* is a photograph by Jacksonville photographer David H. Fauss. The cover depicts the theme of this special issue on indigent care.

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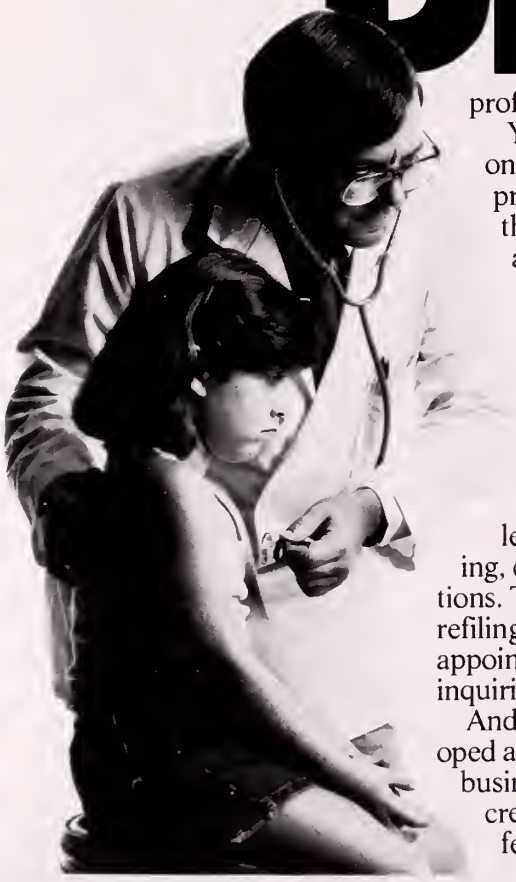
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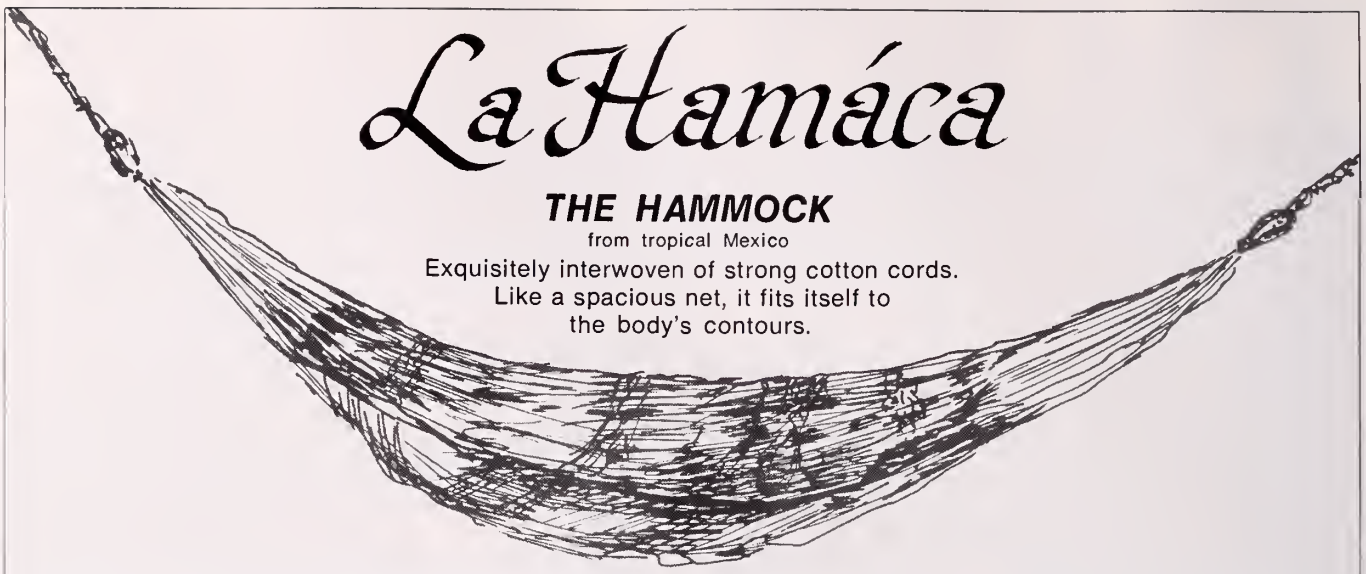
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Reflections on medical ethics and the malpractice problem



In the promotion or consideration of current ethics of medical care, I suppose some reflections on a doctor's relationship to himself, the environment, and the patient are important. If we reflect on ancient history, I suppose we would find the healing art was somewhat limited by today's standards; yet, the physician probably helped improve the lot of a small number of people some of the time. For his efforts, he received in some cases a remuneration which even by standards of that time was probably less than the services were worth. Later in biblical and pre-biblical times, we were told of the Good Samaritan who helped the traveler who had been beset by robbers. Water for his fluids and oil for its healing abilities seemed to be the parable. This Samaritan even paid for the patient's care!

In medieval times and during the Renaissance, care became more sophisticated and the description of disease more complete. Many of the findings, the thoughts and the teachings of that period are in use even today. Remuneration was geared more to the economy of the day and relative value became a significant consideration.

In early America this system evolved and a fee-for-service system present elsewhere for hundreds of years was in vogue. Oftentimes the fee was paid for by "in-kind" services or barter, yet little hesitation for the delivery of care was ever encountered. Somehow much of this changed in the mid-1960s with payment by many private and governmental agencies as well as by other third parties for the administeration of care for the retired and the insured, regardless of need or desire. Medicare became a law of the land. The fee schedules which were promulgated were generous, often exceeding the usual and customary and payment was fairly prompt. "The Golden Age" of medicine was upon us.

At about the same time the Federal Trade Commission declared that the profession of medicine, orderly as it may have been, was not to be the controlling organization envisioned by medical societies. Physicains' rates became paramount. No controls, real or imagined, were to be considered in allowing hospital and staff privileges or in allowing certain practices in a community because that was tantamount to restraint of trade. The so-called ethic of medicine for the payment of services and the control of membership both from the viewpoint and the standards engendered was not considered. Advertising became legal and to some an aid to survival. Violation of these directives could and did lead to complicated, soul-searching court cases with imposition of fines and treble damages when defendants were found guilty.

About this time patients also became plaintiffs in legal action against physicians. The patients realized that the doctor was no longer the monk of the middle ages trying to help them. He was a purveyor of medical science for which they staked a right. People expected value for dollars paid to the provider, be it goods, services or medical treatment. Occasionally the physician, though trying to do an excellent job, might have overlooked simple judgment or was too rushed, preoccupied or hurried to be cognizant of the implications of all of the knowledge at hand. Many times nothing serious or significant occurred as a result, but on occasions these oversights

or perhaps frank errors in judgment led to decrease in value and people's expectations were thwarted. They took their grievances to court and the medical liability crisis erupted because of the willingness and greed of the plaintiffs' attorneys. Basically, people expected too much return for paid dollars which may or may not have been their own. The so-called minimal insurance was just that.

At the same time the patient's rights became paramount, the right to examine for errors, for example; errors in judgment committed in haste, because they often had to be, and then scrutinized and dissected by "Monday morning quarterbacks." A thirty-second decision was debated for two and three weeks in a court/jury setting without the stress and emotional drama of the life-and-death decision of the moment. A life-and-death decision had to be made in an instant. The "economy" of the patient and his rights were all that mattered. The doctor was too responsible and the patient's rights were infringed upon. Therefore, dollars were a retribution. This went often to an emotionally distracted, confused, medically illiterate public. Aristotle spoke often of the importance of the commonest of terms and places while talking in the area of public awareness. This often was not accomplished. It is noteworthy that even today, several years after the onset of the so-called liability problem and crisis, a few physicians still for some reason or another do not take the time to explain and to talk to the patient or his family and relatives. This often translates to a perception of arrogance.

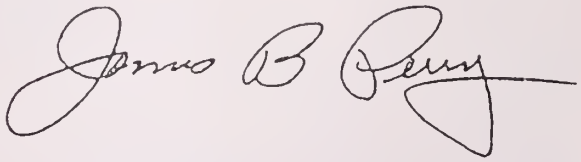
Also, in the mid-60s, the house of medicine had difficulty within. New technology, engineering, and laboratory sciences became more and more important while the art and science of medicine was assumed, probably erroneously, to have a secondary role. We may have come full circle because after the onset of the current crisis most realized that medicine and communications come first, and the other, though important, is not more paramount. A recent public broadcasting program, "Managing Medical Miracles," brought this into poignant focus. The catch-22 of the apparent conflict of decisions and technologies as it relates to ethics of care was dramatically reportrayed. A recent brain death, and the judicial debates about the withdrawing of fluid and nutrition support serve to underscore the dilemma and need for medicine, not courts, to examine this and similar situations within our ethical microscope.

Part of the problem is people. People's rights have been expounded so much by rhetoric that caveats have been created. These rights have been expanded to mean an unerring obligation for physicians and a failure of that obligation to pay in dollars. At no time has society put humanism, frailty, error, judgment or morality into the context of debate or thought.

One can underscore the magnitude of the dilemma of this by the example of a single mother, febrile with needle tracks on her arms, wheeled into an emergency room in the fourth stage of labor with the head of a brain-affected fetus crowning, and the doctor delivering the child through fecal-stained amniotic fluid without gloves and perhaps an open cut on his finger with a statement, "If I didn't do it, I wouldn't be a doctor." Then because the cord was about the neck one or two times, and perhaps hundreds of other reasons, the child has brain damage and an all-knowing proselytized jury convicts him of medical negligence, or perhaps an insurance company settles, because the system is geared to costs so prohibitive, and the court rules so restrictive, that the full background and facts are not allowed in evidence. It is "cheaper" and dollars again replace moral value. These ethical and moral considerations can be juxtaposed in numerous other areas. The artificial heart patient can become depressed because of numerous emotional and family matters and with a mere flip of the switch can terminate life.

It is easy to deal with dilemma and quandary ethics when numerous principles are brought together. It is also academic to discuss bioethical issues which can be thought about for 500 years if necessary. But in the day-to-day care of the patient these luxuries are not practical or permissible. We must nevertheless stop thinking about ethics as right or wrong, but think about values and goals. We must begin to realize that objectives in themselves are occasionally good because they must meet the needs of our patients and ourselves.

We find difficulty when we try to rationalize allegiance to the Hippocratic Oath, care for the indigent patient, and the need from a practical standpoint to be a bit self-serving. Obviously, these issues are significant and presently we have made the choice to address them. Whether or not a pragmatic response occurs is not as important as the fact that we face the problems. The issue is simply that we have reflected, and, perhaps, in doing so will be better prepared with realistic solutions. Regardless, the patient, the physician, and society will benefit. Your help, thoughts, and reflections are invaluable.



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Indigent care: overview of the problem and the need for an investigative approach to its solution

This issue of *The Journal* reflects the eruption of concern about providing adequate medical care to the needy that pervades the FMA leadership and some public officials. As federal support ebbs the states and localities are coerced to magnify their economic commitment to social programs; medical care is the most costly of all these programs.

Florida is home for more than 4.3 million people living in families with annual incomes less than 150% of the poverty level (the poverty level for a typical family of three is defined as an annual income of $13,860 in 1986).[1] Of these 4.3 million people, 533,000 receive Medicaid; an additional 1.024 million other persons have no medical insurance at all and 313,000 others lack continuous medical insurance coverage. Thus at any one moment close to 1.9 million of the total population of 12 million are medically needy.

The state Medicaid program costs $1.3 billion each year. If we adjust this figure by subtracting the cost for intermediate nursing care ($359 million), nursing home ($67 million), state hospital services ($8 million) and intermediate care services for the mentally retarded ($126 million — which are services that probably would not apply to the non-Medicaid population) then the cost of the service applied to the 533,000 population is about $700 million. Since the number of Medicaid eligible people compromises about 29% of the medically needy population of the state, we might, by extrapolation, calculate the cost for an indigent program at $2.7 billion per year, or over $1,430 per indigent person. This figure is actually understated since physicians and hospitals are not fairly reimbursed for their costs for caring for indigents. Despite its understatement this figure still exceeds the cost of some private medical insurance programs. One reason for this large expense for Medicaid recipients is the large charge for hospital in-patient and out-patient services ($388 billion) or over $428 per Medicaid recipient — another figure that exceeds the experience of many private medical insurers. Obviously the financial success of any new indigent program must seek to minimize these relatively high cost hospital services.

As Charles McIntosh, M.D., and his colleagues stress in the following article of this issue,[2] physician services account for only 4.6% of the Florida Medicaid dollar. This strikingly contrasts with the 25% that physicians and dentists services consume. Florida Medicaid has squeezed physician reimbursement so horribly that most doctors (65%) cannot afford to participate, particularly the primary care doctor who works in a relatively inexpensive out-patient setting and who has no procedure charges with which to recoup his cost of indigent care. Would it not seem reasonable to test the hypothesis that greater physician involvement, brought about by reimbursing the doctors at a fee that would at least cover their expenses for providing care to the indigent, might actually significantly reduce the total medical cost per Medicaid beneficiary? Many problems, now shunted to the hospital setting, could possibly be more economically handled by the private physician in his office.

The Florida Department of Health and Rehabilitative Services published, in July 1986, a plan to provide primary health care to the state's indigent population.[3] The plan contained 74 recommendations for expanding and improving the current program. The plan however is modest. It is designed to extend care to an additional 230,000 persons and increase the total enrollment of the indigent care covered program to about 760,000 of the approximately 1.9 million medically needy in the state. It is obvious that this

proposal will not resolve even half the indigent care needs of the Florida population.

Florida legislature stated, in the 1984 Health Care Access Act that "it is declared that access to adequate health care is a right which should be available to all Floridians . . ." The statement was rhetorically fetching but legislatively limp. Insufficient funding was allocated to measurably alter the indigent care needs in any meaningful fashion.

Any program must, of course, avoid the exaggerated presumptions of the "Dare to be Great" era of the Johnsonian 1960s. This political hyperbole has been subdued by the rediscovery of reality. Optimization of finite resources rather than "alms for everyone" is the demand of the day.

Physicians have traditionally involved themselves in indigent care. Most of us trained in indigent care hospitals for years prior to entering practice; many physicians contribute their services to indigent care clinics and serve the poor in their offices. The size of this unreimbursed physician contribution has not been measured for the entire state. A study conducted among the physicians of Volusia County estimated that the median physician donated $17,000 per year to indigent care. For surgical specialties these numbers were considerably larger; and in specialties such as neurosurgery, some physicians contributed $100,000 a year per person of uncompensated indigent care.

Since physicians provide so much indigent care they are enriched with the unique perspective about the difficulties that attend to providing this care. A wise legislature will consult upon this physician experience in formulating any indigent care program. The articles that follow this editorial solicit support for many components that should be included in a revised indigent care program. I would like to expand this list by adding three additional items that should be incorporated into it: 1) the acknowledgment and provision for the heterogeneity of the indigent population; 2) the need for a research-based approach to the problem; and 3) the need to confront the realities of offering only limited and necessary rather than comprehensive services.

One gaudy error in the assumptive world of those of us who think about indigent care is the consideration of the indigent population as a homogeneous group. Poverty may be the escutcheon of the indigent, but only in their fiscal status are indigents alike. The poor are obviously diverse in their educational, cultural, physical, racial, intellectual, and geographic compositions. Also individuals vary greatly in the time spent in poverty. Divorce, illness, or the recent loss of a job may temporarily thrust a person and the family onto the roles of the impoverished but in about two years most of such individuals will have been rehabilitated into a productive, independent role in society.

In contrast, to the temporary indigent are the hard-core permanent indigents. Some of these people lack the psychiatric, intellectual, biologic or physiologic traits that permit them to financially survive. Many are well motivated and deserve society's protection. Unfortunately the indigent subset is also populated with a large number of the "attitudinally impoverished." These are the individuals who are not physically or mentally deprived but rather lack the motivation to help either themselves or those around them. These are people who dare the physician to try to cure them, fail to keep their appointments and rarely take their medication. These folk are the "knights of the negative." They are masters of passive aggression, highly resistant to any self help and quizzically scorn any physician who suggests weight loss, exercise, cessation of smoking, or any other preventive medicine program. These people issue from all demographic groups. Their numbers are significant; about 30% of the patients attending our arthritis clinics for the indigent can be classified within this group. Obviously interacting with these people is highly frustrating and wasteful of medical care resources. Such patients deprive even the most idealistic physician of any emotional, intellectual or professional reward.

The great diversity of the indigent population may impact substantially upon the outcome of their medical care. Prior to flushing another half billion scarce dollars into an indigent medical care program, this heterogeneity needs to be acknowledged and quantified and the effects of such diversity upon patients' health outcome should be measured by carefully designed research programs. The results of this research could illuminate potential areas of wasteful allocation of resources and suggest alternative methods of dealing with persons who reside in the various sub-groups of the impoverished population. Perhaps pilot programs for indigent care could be established in a half a dozen counties, that are representative of the different areas of Florida. Perhaps also the experts from foundations interested in health care, such as the Robert Wood Johnson Foundation, could be recruited to help design and analyze the research. By approaching the indigent care program from this research vantage, the state of Florida may be truly innovative and provide lessons for medical care that are applicable worldwide.

In a recent issue of *Science*, Drs. Richard Wyatt and Evan DeRenzo[4] decried the manner in which social welfare programs become public policy. The remarks were stimulated by reflections on the 1960s policies in which hundreds of thousands of mental patients were discharged from chronic hospitals with no concern given to their ultimate social outcome. These deinstitutionalized individuals were converted into the homeless, mentally-ill, needy of today. Drs. Wyatt and DeRenzo chastised policy makers for adopting social programs without first performing controlled and replicate experimentation to measure

the outcome and wisdom of the policy. "Before we prematurely institute new public policies, we should collect the necessary data to rationally initiate social welfare system changes." These principles certainly must be applied to the indigent medical care system in the state of Florida. Yet a review of the proposed budget for the HRS Primary Care Health Plan for the needy reveals no research funding beyond 1988 and only $500,000 for 1987-88. It is inconceivable that any sensible legislator with significantly limited financial resources would pursue the development of such a massive program as indigent medical care without first establishing goals, and secondly continuing to monitor, analyze, and assess the outcomes of the programs. The difficulties of indigent care are too knotty to yield to opinion or to fusty and failed solutions of the past.

Rationing of health care must be addressed by any health plan for the poor. The concept of limiting health care to people based upon their ability to pay may be ethically and politically repugnant. However, medicine is confronted with a dilemma: we can either deliver some essential care and curtail the frills or we will not be able to deliver health care to the poor at all. Health care costs continue to escalate at 8% per year despite the deflationary economic environment in which we live. That means that the costs of an indigent health care system will double every nine years. If the initial annual cost of an expanded indigent health care system is $1.7 billion then the cost will exceed $3.4 billion per year within a decade. That amounts to over $230 of tax dollars per captita (or $920 per family of four) for maintenance of the indigent care program alone within the state. The growth in the national economy appears to be limited to about 3% per year in the immediate future. One does not need to be mathematically deft to recognize that any indigent care scheme can readily bankrupt the taxing capacities of any state. Thus, despite the emotionally unappetizing flavor of a rationed medical system for the indigent, rationing must be acknowledged from its inception.

Certain limitations in medical care are appropriate and have been accepted, de facto, within the present medical tradition for years. Cosmetic surgery, organ transplantation, and heroic terminal care are restricted in many instances. Furthermore, many medical insurance policies delimit the types of procedures that may be reimbursed. In many HMOs, patients with angina pectoris or myocardial infarction are rarely offered cardiac catheterization or subjected to bypass surgery. The citizenry has tacitly accepted some curtailment of medical care. Some expensive types of diagnostic procedures can also be limited. An example in musculoskeletal disease is the increasingly widespread use of magnetic resonance imaging (MRI) scans for low back pain. This procedure adds little to the diagnostic accuracy of low back pain and the cost of a single procedure could pay for a total evaluation and an entire year's cost of care for most individual patients. Similarly, the use of the CAT scan in many cases of low back pain could also be restrained. Many of these are obtained to prevent malpractice risk. If, as alleged, the practice of defensive medicine accounts for 30% of health expenditures, then the resolution of the malpractice debacle could happily deflate excesses in the utilization of some expensive technology.

The use of the medical care system by the indigent population may have to be prioritized for economic reasons. Full payment for and educational encouragement to obtain the adequate treatment of certain conditions which generate much greater economic cost if untreated (such as hypertension, pregnancy, or diabetes) or for the management of conditions that impair the individual's ability to work productively may have to be allotted top priorities. This proposal is certain to roil the humanistic sensitivities upon which we were medically weaned; nevertheless, a system that incorporates the principles of prioritization and constriction is certain to improve upon the current chaos in which many indigent are comprehensively denied care (except for emergency or terminal states) because of the lack of funding.

When one tussles with the challenges of the indigent care problem one is overwhelmed. Hopefully the legislature will not resolve these difficulties by excavating the embalmed solutions of the 1930s and 1960s, i.e. by burying the problem beneath a heap of inadequate funding and layers of excessive regulation. Rather let us encourage the legislature to approach the indigent care problem in an evolutionary fashion by sponsoring a host of controlled research projects that are parochially based and directed and are permitted to adapt to the needs and resources of each community. The efflux from such a flexible, dynamic policy may reveal a variety of affordable solutions to the perplexities of indigent care.

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Muscular Dystrophy Association, Jerry Lewis, National Chairman

Testing the Florida physician for drugs: quo vadis?

There is a current proposal to start testing Florida physicians on a voluntary basis for cocaine, opiates, and marijuana by urinalysis. The individual physician would not only decide whether or not to enter the program but would also decide when to bring a urine sample to the approved laboratory, and after seeing the results would decide whether or not to have the results sent to the medical society. Upon receipt of negative test results, the society would issue a certificate that the physician is drug free. No course of action has been designated for the possible event of receiving a positive urinalysis.

It is beyond the scope of this article to discuss the pros and cons of an involuntary drug testing program other than to point out that some have been very successful in reducing drug abuse and also that there are serious questions about the infringement on the constitutional rights of individuals. There is also an issue of the right of patients to be safe in the hands of the people they must trust.

In considering any program for drug testing we must take into account not only what goals we hope to reach but what factors may produce unexpected or unwanted results. Do we want to reward those physicians who can present a drug-free urine sample to a laboratory whether or not the sample is their own urine? Are we willing to test a sample which has been taken at a time specially chosen by the donor to be drug-free? Are we trying to protect the public from drug-abusing physicians? Do we hope to find the drug-abusing physician who is, by definition, impaired so as to try to salvage him or her and the associated family? Do we want to demonstrate public leadership, by example, towards a satisfactory substance-free life? Do we merely want to give the appearance of being "good" or above suspicion?

Fairness must be considered. What of the drug free physicians who merely exercise their civil rights by choosing not to enter the voluntary testing program? How may they be safeguarded from scorn or suspicion from peers and public? Why test primarily for cocaine and marijuana, substances favored by younger physicians, while not testing for alcohol, amphetamines, sedatives and minor tranquilizers, historically favored by the older ones? Safeguards must be available to prevent harm from false positives or mislabled specimens. Confidentiality must be maintained.

Surely if we have a voluntary drug program at all, it must be meaningful in terms of accomplishing some of the positive goals listed above. Certainly, we also want it to be credible to the public and those knowledgeable in the substance abuse field. We especially wish it to help us help our troubled peers who are in danger of losing their health, family, profession or their very lives, as has happened all too frequently.

I, therefore, propose consideration of the following minimum elements for a voluntary drug testing program:

1. Encourage all practicing physicians to join the voluntary drug testing program whether or not they are members of the Florida Medical Association.
2. Participating physicians must agree to submit a urine specimen within six hours of notice by the local medical society office. These times should be announced without notice, preferably on a Monday morning on a random basis. Specimens should be obtained three or four times a year with the understanding that only two may actually be analyzed.

3. The collection of the samples should be observed, the label initialled by the physician and observer, and a chain of custody of the specimen be established.

4. All results are to be forwarded to the medical society. Positives should be double-checked. A follow-up specimen may be indicated.

5. The specimen should be tested for cocaine, amphetamines, opioids, alcohol, minor tranquilizers, other sedatives, and marijuana.

6. Physicians with positive tests should be referred to the impaired physician committee of the local medical society for further investigation and appropriate help.

Modifications to the above may be necessary depending on the objectives desired by the FMA. Above all, the program should be well thought out so as to assure fairness, usefulness and credibility.

Burton Podnos, M.D.
Rockledge

Bad apples in both barrels

In the medical profession's liability crisis, it might appear that we are assuming an unenviable posture fighting calumny with calumny. The mistakes of trial lawyers in defense and prosecution continue to be publicized by the lawyers themselves in their attempts to overthrow verdicts with death penalties. That makes us all wonder if all trials are so flawed. If so, lives and deaths of their clients may be affected just as much as the mistakes of the medical profession may affect their patients.

If we made attorneys fiscally responsible for their human errors then litigation would probably be thrown in such a muddle that trial lawyers would self-destruct, and we could start all over in a new system for getting justice in our dealings with each other.

I would prefer the Christian attitude of maintaining trust and support from our friends and turning the other cheek to our adversaries. But, we are about to run out of cheeks.

We do need to control or destroy those scavengers who grow fat on human miseries. Some trial lawyers too often fit that category. Some of us in the medical profession who spend our lives trying to alleviate the human miseries have been merciless in our charges, but please remember that when we are faced with yearly liability insurance premiums of $10,000 to $100,000, overcharges become obligatory.

The ramifications of varied interpretations of our myriads of laws have made litigation too expensive and justice too illusionary. In some way we must simplify laws and return to more arbitration and less litigation.

It has been stated that confession is good for the soul, and I must confess that I have seen about as many ambulance-chasing doctors as ambulance-chasing lawyers. Being an optimist, I believe that most trial lawyers are motivated to get their fellows out of miserable situations, and I would be the first in line to seek their help in times of trouble. Like President Roosevelt, I would like to call down a plague on both our houses when the shoe fits.

H. L. Harrell Sr., M.D.
Ocala

A rebuttal — "know thyself"

Apparently it was not enough to publish the cynical article entitled "Caveat, Doctor," by Rose London, M.D., in *Miami Medicine* (November 1986); it had to be reprinted in *The Journal of the Florida Medical Association* (December 1986, Vol. 73, No. 12)! It is difficult to say whether the article was intended as inflammatory anti-government propaganda or a fluffy piece of malicious humor. If I know Rose (and I should as we were classmates at N.Y.U. College of Medicine, class of 1941), I suspect it was more of the former than the latter.

While it is true that a number of the statements found in the article appear in the HCFA regulations, for the most part these are taken out of context and sprinkled so liberally with distortions, sarcasm and innuendo as to render the article unworthy of serious consideration. The regulations are guidelines intended for use by the initial review coordinator to flag suspect records and no physician advisor would interpret them as Dr. London portrays them. I have been involved in peer review for over 15 years, initially as a member of the DCMA Peer Review Committee in the early 1970s, then as Medical Director of the Dade-Monroe PSRO from 1975 to 1980, and more recently as a member of the Quality Assurance Committee (Birmingham area) of the Alabama Quality Assurance Foundation from 1982 to date and of the hundreds of physicians that I have met engaged in a like role, I have never known one who did not perform his duty in an honest and conscientious manner, sometimes leaning over backwards to rule in favor of a doctor under review. Perhaps Dr. London and those of like persuasion should spend a little time to analyze what occurred in the past in patient care to trigger these objectionable regulations.

There is an editorial in the November/December 1986 issue of *Medical Malpractice Prevention* by John W. Scanlon, M.D., Associate Professor of Pediatrics, Georgetown University School of Medicine,

Washington, D.C., that is not only worth reading but worthy of serious consideration. After a litany of suggestions for avoiding malpractice suits, Dr. Scanlon rolls out the favorite admonition, "practice high quality medicine." But he follows this with this statement — "Oh sure, some statement is usually found in the first paragraph of any treatise about the malpractice problem that quality care is the best malpractice defense. But organized medicine really has not done a bang-up job defining quality of care, or, more importantly, ensuring that medical care is regularly reviewed for excellence. Much of the peer review process is window dressing. Sanctions against physicians who repeatedly mess up are unusual. There is an indistinct line between colleague protection and cover up . . . " Later in the editorial, Dr. Scanlon continues, "We in medicine can utter outraged cries that insurance premiums are excessive, malpractice awards too high, and that patients demand too much, too often. But none of this will be heard unless we offer meaningful, effective, ongoing medical practice reviews with rewards for high quality care and sanctions for deficiencies . . . "

Socrates is quoted as saying, "There is one thing that I know and that is that I know nothing. Know thyself." Yes, doctor, know that we are now reaping the harvest of many past years of arrogance, avarice, and non-accountability.

Franklin J. Evans, M.D.
Fayette, Alabama

Editor's note: Rose London, M.D., was not exaggerating when she wrote about some of the banalities found in the PRO guidelines. She may have sounded sarcastic in her views, but she was telling the truth about current medical reviews as mandated by the state PRO. It is obvious Dr. Evans has lost touch with the realities of medical practice and badly needs to come down to earth from his ivory tower to re-acquaint himself with the situation.

Last words on Machiavelli

I was delighted to hear from my colleagues, Dr. Bukantz and Dr. Lockey (*JFMA*, January 1987, Vol. 74, No. 1) but I must disagree with their interpretation of my article, *Messages From Machiavelli (JFMA*, October 1986, Vol. 73, No. 10). The purpose of that article, as a thorough reading will reveal, was not to espouse amoral power wielding as a modus operandi for physicians. Rather, my purpose was to explore and to unshroud the elements of power, as practiced in the real world, and to alert and warn physicians as to the manipulative methodologies that will confront us as medicine becomes more politicized.

Doctors have inherited a tradition of ethical standards that reach back into antiquity. The integrity that those standards impose must always be applied in our practices, in our science, in our teaching and in our dealings with our patients and colleagues. But to assume that the ringbearers of political power adhere to these same ideals and principles is naivete. "Machiavellianism," as used by Drs. Bukantz and Lockey, has continued to thrive throughout the centuries. We, as physicians, must recognize this actuality, expect it, and approach the political system with the skepticism that it engenders; to do otherwise is to enter battle waving icons and chanting hymns in the face of a foe who is equipped with modern weaponry. Self-imposed carnage is the only outcome of such ingenuous behavior.

Drs. Bukantz and Lockey report accurately that Machiavelli expressed a more idealistic set of political sentiments in his "Discourses." Unfortunately those sentiments fail to permeate the ethical marrow and fail to govern the actions of history's political leaders (e.g., the duplicity of our present national administration, vis a vis Iran, doctors, etc.). Since those more idealistic sentiments lack a realistic root system in the realm of politics, the "Discourses" have been ignored and remain unread except by the few scholars interested in Machiavellian arcana.

Jacques R. Caldwell, M.D.
Daytona Beach

Let us put an end to the malpractice mess

The medical profession feels that patients injured from true malpractice should be properly cared for through appropriate insurance coverage. We do not feel that their lawyers should become instant millionaires. The money awarded should go for the care of the injured party. However, insurance premiums must be at reasonable rates, affordable by our patients, because they are paying these premiums through increased medical costs. Rising malpractice premiums are one of the primary causes for rising medical costs and all conscientious physicians are concerned about bringing these costs under control.

Our inability to pay these premiums leaves many of our patients at risk if malpractice is committed. This is wrong. Therefore, limiting exposure must be considered as a means of patient protection as well as personal protection from those unfair suits brought because of a poor result, a complication of surgery (not caused by malpractice), or a desire to get rich quick.

We are tired of being made the scapegoats for rising medical costs. As in any business, increased vendor costs are passed off to the consumer. We are now, diligently, trying to bring down these medical costs to our patients by protesting insurance premiums that are outrageous and unaffordable. We are trying to bring down some of these costs by protesting against a legal system that has run amuck.

Approximately 5-10% of every doctor's practice is, and has been, towards indigent care. In the past, emergency room call always encompassed a certain percentage of indigent care, which was standard and which was expected. Trauma centers have increased this indigent care, inappropriately, to the point that many physicians could not properly care for their private practice, which pays the bills. Being up all night long, on multiple occasions, does not do justice to those private patients waiting in the doctor's office, the following morning, for the physician whom they rightfully expect to be alert and sharp. This is unfair to those who equally deserve medical care. It is incomprehensible as to why the medical profession is the only one that the media and politicians expect to donate free care to indigents. If these same indigents had good food, clothing and shelter, their medical needs would probably decrease proportionately. Yet, we hear no hue and cry from our elected officials or the media about having the building industry donate free housing, the food industry donate free food or the clothing industry donate free clothing. For some reason, doctors are expected to do what is not expected of any other citizen who is supposed to have the same humanitarian concerns.

Indigent care is and has been the county's responsibility. Jackson Memorial Hospital, for example, was built for that purpose. However, because of the financial crunch causing a loss of many teachers at the medical school, along with decreasing salaries to those still there, Jackson Memorial Hospital has increased its number of private beds as a means of compensation. Indigent beds have been decreased and those beds should be for all those indigents now being tossed out onto the community, pushed by a political and media blitz as to how all private hospitals must share in this indigent care.

Financial loss to private hospitals punishes the private paying patients because, again, they must pay increased medical costs to compensate for this loss. Financial loss also means a lack of funds for modern state of the art equipment and facilities, which the private paying patient has every right to expect. The medical profession is fighting aginst this injustice. Yet, we still continue to see our fair share of indigents also. These numbers cannot be increased and the county must assume its proper responsibilities through Jackson Memorial Hospital. For a long time, the State of Florida has collected bed taxes with the money earmarked for indigent care. Millions of dollars sit in banks, collecting interest, and our politicians do not distribute the money because they do not know how to.

For years, the trial lawyers blamed the problem on doctors committing too much malpractice. For years, we explained that we practiced the same medicine in Miami as is practiced elsewhere in this country. Therefore, why are our malpractice premiums the highest in the nation and why do we have so many lawsuits in Dade County? For years, the trial lawyers preached that we must clean our own house and for years we asked them to give us laws that allow us to do exactly that. To date, we have none, but several years back we did, only to have our last vestige of hope taken away by the state legislators when they voided the law making it mandatory to be a member of the county medical association in order to have hospital staff privileges. When the trial lawyers found out that liability insurance premiums had reached exorbitant levels for businesses and industry, to the point that many businesses and industries closed or failed, they now decided to change their tune and blame the insurance companies. There is no question that we are being raped to a great degree by companies who claim losses and whose books and figures we either cannot see or do not understand when shown to us.

The majority of attorneys in this town are good, competent, honest and conscientious. They are as equally concerned about this problem as we in the medical profession are and they are equally outraged at the obscene fees taken by many trial lawyers on their so-called contingency cases. A trial lawyer deserves a fee for his services, without question, but when a jury awards X dollars for the care of a human being injured through true malpractice, how can anyone be so callous as to take up to 50% of this money as a fee if they truly care about that injured person? That money was awarded for the care of the injured person and that is where that money justly belongs. If the trial lawyers really care about their injured clients, then why not use double or nothing in the contingency system? If their standard fee is $150 per hour and if they win, then take $300 per hour. But, let them justify their time records before the courts and the losing party.

President Reagan's commission reported that capping awards only in pain and suffering at $100,000 would significantly decrease malpractice premiums. California has capped pain and suffering awards at $250,000 and found out that over three years insurance premiums decreased 17%. Our legislature, because of the pressure from the trial lawyers, agreed to cap at $450,000, which probably will have little to no effect and, if it does, we probably will not see it for many years. The new liability laws that were to have gone into effect January 1, 1987, are being challenged in the Supreme Court (all lawyers) by the insurance companies and trial lawyers, because it will hurt their

pocketbooks and benefit the public. If they succeed, the state reverts back to the old law, mandating malpractice insurance for all doctors in Florida but putting no controls on the premiums allowed to be charged by the insurance carriers. If this is allowed to happen, it is akin to letting the fox in the chicken coop. The public may just as well empty their pockets into the mail slot of the Trial Lawyers Association. Medical care will be unaffordable to most and that is when our bureaucrats in Washington, who brought you Watergate, Iranscam, the U.S. Postal Service, Medicare, Medicaid, defense overpayment frauds galore, will decide it is time they stepped in and socialized medicine. The public can then expect to receive the worst that medical care can offer if the VAs and military medicine are any example. The last thing a socialized system has money for is medical care.

American medical care has been the greatest the world has ever known. People come to the United States from all over the world for medical care, recognizing our superiority. We cannot destroy this system built through free enterprise. The public must rise up and put a stop to what is happening to an honored profession full of dedicated, conscientious and caring people. We must put a stop to those who desire to drag this honored profession into the muck. Allow us the ability to go back to practicing medicine and caring for those who need our help, without constantly having to worry about the hoards of vultures trying to pick our pockets without any concern for the public or their welfare.

The concept of giving those who service trauma centers sovereign immunity is a noble gesture. However, we must look at Jackson Memorial Hospital's experience with sovereign immunity in the courts. The courts, in their defense of the legal system, have overruled sovereign immunity on almost every case brought against Jackson Memorial Hospital. The concept of sovereign immunity is fine if the courts abide by it and honor it. But if they do not, then sovereign immunity is no answer at all.

What is a viable answer is the concept of capping awards against physicians at a reasonable level and any amounts above that would be taken from a state fund built up by a small percentage increase in taxes. It makes sense, being that the public is paying the bills anyway. The state would control access to the fund to ensure that astronomical amounts are not withdrawn for sympathy verdicts, for poor results, for a complication of surgery not caused by malpractice, or for an astronomical judgment above and beyond the injury sustained. We must also have control on the contingency fee system and the vast majority of monies awarded in a true malpractice case must go for the care of that injured party. After all, that is and should be the primary concern of all of us. We must control the beds for indigent care at Jackson Memorial Hospital and also control the free medical care given by Jackson Memorial Hospital to foreign nationals who come here solely for the purpose of slipping into the clinic system for their medical care. We must insist that our state legislators dispense the money sitting in the state's account for the purposes it was put there. The vast majority of this money must come to Dade and Broward Counties.

Mediation panels must be reinstituted. Insurance company antitrust exemptions must be repealed. Awards for pain and suffering must be capped at a rational $100,000. Premiums for liability insurance to all businesses must be regulated and controlled. The doctrine of joint and several liability must be reconsidered and revised. We must have structured settlements, consider removing malpractice from the tort system and putting it into a Workers' Compensation or no fault insurance system. We must see to it that programs such as Workers' Compensation, Medicare and Medicaid pay their fair share of medical costs. Jackson Memorial Hospital must be sufficiently funded.

The media must assume its proper responsibility in properly educating the public as to this problem and other problems concerning their health and welfare. We must insist that other citizens in this community assume equal responsibility for indigent care.

This article also appeared in the *Miami News*, February 16, in a modified version.

Richard L. Glatzer, M.D.
President-Elect
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Miami

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The Florida Medical Association and indigent care: an agenda for the future

Charles B. McIntosh, M.D.; Charles P. Hayes Jr., M.D.; Donald G. Nikolaus, M.D., and E. Russell Jackson Jr., M.A., M.P.H.

At the October 17, 1985 meeting of the Board of Governors of the Florida Medical Association, the Board approved a recommendation on indigent care as developed by the FMA's Council on Medical Economics and endorsed by the Association's Council on Legislation. This recommendation stipulated:

> That the FMA seek through legislative means adequate funding of indigent and medically indigent health care through a broad based revenue funding source or sources; and further, that services provided to the indigent and medically indigent be delivered through a coordinated public and private sector provider system that includes independent practitioners with emphasis on primary care and preventive medicine.

The FMA's House of Delegates adopted the recommendation as a policy statement on indigent care at its Interim Meeting in January of 1986.

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Dr. McIntosh is Chairman of the FMA Committee on Indigent Care, Dr. Hayes is Vice Chairman of the Committee on Indigent Care and Chairman of the FMA Council on Medical Economics, Dr. Nikolaus is Chairman of the FMA Committee on Government Programs, and Mr. Jackson is FMA Assistant Director of Medical Economics.

The FMA's policy statement on indigent care is by design broad in scope. Yet it sets forth certain basic principles of FMA policy. The support for a broad based funding source or sources is an expression of a principle that the responsibility for the financing of indigent care resides with society as a whole, not with a segment of the population or any provider group. This principle is in direct contradiction with current Florida law that imposes a 1.5% tax on net operating revenues of hospitals to finance indigent care.[1]

The second basic principle is that services to the indigent and medically indigent be delivered through a coordinated public and private sector provider system. This principle recognizes that there is an appropriate role for the public sector and a role for the private sector in the provision of indigent health care services, and that these roles should be carried out not in isolation but as part of a coordinated system.

The third indigent health care principle is that the delivery system should include independent practitioners. This principle does not oppose prepaid financial arrangements or such organizational alternatives as health maintenance organizations. Rather, it is a statement that in a competitive environment independent practitioners have a right to compete and should not arbitrarily be excluded from any statewide program designed to provide services to indigents.

The fourth and last principle encourages the development of a provider system for indigent care that places emphasis on primary care and preventive medicine. The rationale for this principle is simply that the early detection and treatment of the disease process have several consequences of benefit to society as well as to individuals, including cost containment features and enhancement of the health status of the indigent population. Other benefits could be

reduction of emergency room use and costly hospitalization that occurs through latent care. Emphasis placed on prevention of disease or its progression into more morbid stages or premature death is a natural consequence of stressing primary care as has been proven in private sector medicine and the increased importance ascribed to primary care by the medical profession in general. Prevention as a health services philosophy also entails other aspects indigenous to both primary medical care and public health. This includes the rehabilitation potential that improves the opportunity of sick or injured employees returning back to the work force, thus reducing the ranks of the unemployed indigent.

Florida's Medicaid program ● In developing an agenda for the future in terms of specific recommendations, or principles as adopted by the FMA, that the Legislature should follow with regard to a State of Florida indigent care program, it is prudent to take a look at Florida's Medicaid program in terms of what may or may not be expected from it as a key factor in future indigent care programming. That such an exercise is a good point of departure for addressing indigent care is the principal thesis raised by Cathy Schoen of the Services Employees International Union, Washington, D.C., in a 1983 presentation made to the New York Academy of Medicine's Committee on Medicine in Society.

Ms. Shoen stated that "... if one visited the Medicaid policy and decision making halls in Washington during the last couple of years, one might have thought that one was in the wrong room. Discussions about preventing death or disability, relief from pain, rehabilitation or equity were notably missing from forums on Medicaid. Contrary to media accounts, discussions concentrated neither on health care cost containment nor on innovations in the Medicaid program. Instead, the concern was mainly on cutting federal budget dollars."[2]

At a time when Florida has been willing to interject more money into Medicaid, the federal government has become budget conscious and has embraced a public policy that says in essence that a multitude of problems and programs that were once the responsibility of the federal government should primarily belong to each individual state. Inherent in that national policy is the new federalism approach that returns certain federal dollars to states consolidated into block grants, instead of independent federally funded programs having no state option as to how such funds can be expended.[3] Thus, while indigent care may be a nationwide problem, states have in effect been induced to address it individually in spite of such mammoth federal programs as Medicaid.

Many people declaim Medicaid without really knowing what it is in the context of federal programs or what it was intended to be. Title XIX of the Social Security Act Amendments of 1965 provided for a program of medical assistance for certain low-income individuals and families. It succeeded earlier welfare-linked medical care programs, most notably the Kerr-Mills program of medical assistance for the needy elderly.

Medicaid is financed jointly by state and federal funds. The federal contribution to the cost of the program currently ranges from 50 to 77.55%.[4] The Florida Medicaid program is funded at a level of 56.16% federal financial participation and 43.84% from state general revenue.[5] Medicaid is basically administered by each state within the framework of federal requirements and guidelines set and enforced by the national and regional offices of the U.S. Health Care Financing Administration (HCFA).[6]

Medicaid was designed to provide medical assistance to persons eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act: the program of Aid to Families with Dependent Children (AFDC); and the Supplemental Security Income (SSI) program for the aged, blind and disabled. Receipt of a welfare payment under one of these categorical programs generally means automatic eligibility for Medicaid.[7]

States may also provide Medicaid to the "medically needy;" that is, persons covered under one of the cash welfare programs who have enough money to meet their basic living expenses but do not have enough to pay for their medical care.[8]

Medicaid does not provide medical assistance to all of the poor, as Florida's large non-Medicaid eligible population attests. Further, low income is only one test of eligibility. More importantly, one must belong to one of the categorical groups designated for welfare eligibility to be covered.[9] Herein lies the fundamental problem with the over $100 million tied-up in Florida's Public Medical Assistance Trust Fund. The Health Care Access Act of 1984 assessed a 1.5% tax on the net operating revenues of hospitals. The act stipulated that these funds would be used solely for the purposes of Section 9 of the Health Care Access Act. Section 9 expanded Medicaid services to financially eligible individuals who are children in intact families. It also expanded Medicaid to a second category to cover financially eligible parents with children under age 18. The third category extended Medicaid coverage to financially eligible married pregnant women.

The Department of Health and Rehabilitative Services and the Florida Legislature thought that 50,000 new persons would become Medicaid eligible under these enhancements.[10] Instead only 2,830 persons were enrolled in Medicaid under the three new categories.[11] Consequently, the anticipated use of hospital services by large numbers of new Medicaid eligibles did not occur. This created the two-edged sword of hospitals paying a tax and continuing not to be reimbursed for uncompensated care provided to the non-Medicaid eligible indigent, despite

over $100 million being available in the State's Public Medical Assistance Trust Fund.

Beginning July 1, 1986, the Department of Health and Rehabilitative Services established a Medicaid medically needy program, also under the provisions of Section 9 of the Health Care Access Act. This Medicaid expansion was for the categorically eligible with income levels raised to 133⅓% of the payment standard for AFDC money. Five thousand two hundred persons are now eligible under this expansion, which is still far below the number of persons anticipated when the tax was imposed on hospitals.[12] Thus, Florida, has a narrow based tax that generates a considerable amount of revenue for indigent care. Such funds can be spent for very limited categories of the indigent population.

For years, Florida's Medicaid program has been depicted as one of the worst in the United States. It is a minimal program. Florida ranks 42nd in the nation in payments per Medicaid recipient and 44th nationally in payment per capita.[13] Yet Medicaid expenditures for fiscal year 1986-87 were projected at $1.3 billion or one-tenth of the entire budget for the State of Florida (this includes federal matching funds which for fiscal year 1986-87 could amount to over $700 million). Forty-two percent of Florida's Medicaid expenditures pay for long term care, including nursing homes, intermediate care service for the mentally retarded, and state mental hospitals.[14] Thirty point seventy-five percent is spent on acute care (non-physician services). The remaining 27% of the service costs go for non-institutional services of which physician care is a meager 6% of the total Medicaid dollar.

Table 1 displays projected Medicaid services and expenditures in Florida for fiscal year 1986-87.

It becomes clear from the data in Table 1 that Medicaid in Florida is anything but a program that emphasizes primary care and preventive medicine. Despite efforts to establish prepaid plans and other innovations in recent years, institutional services remain the greatest sources of expenditures. Additionally, only a little more than one-half million (536,000) persons in Florida are eligible for these services.

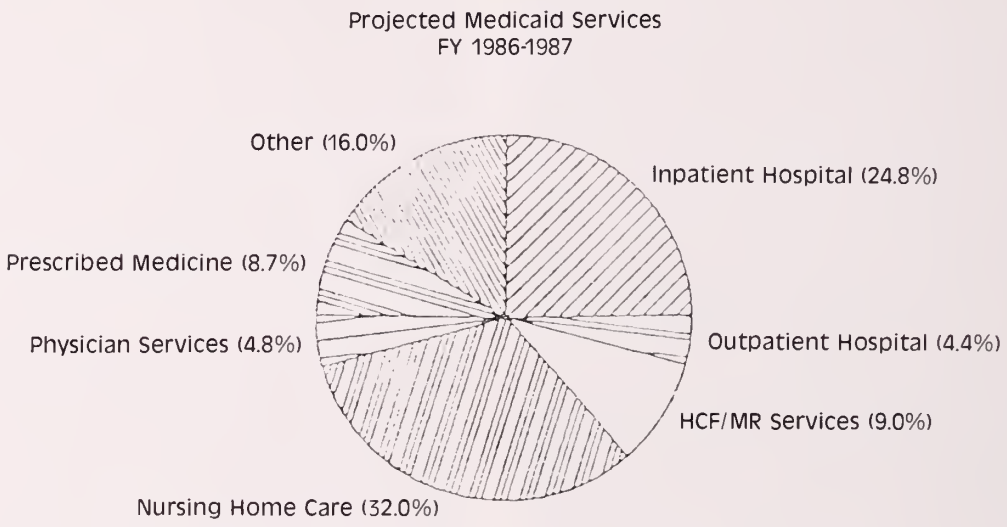
In fairness to the Medicaid program, one must recognize that the Florida Legislature was reluctant to become involved with the program at all after its enactment by the U.S. Congress 22 years ago. Medicaid was originally intended to cover the medical costs of everyone in the categories mentioned. However, in 1967 the U.S. Congress amended the law " . . . to make it crystal clear that it had not intended Medicaid to be anything more than welfare medicine. The amendments placed a ceiling on the family incomes (of those falling into one of the eligible categories) above which no federal matching funds would be available. States would no longer receive reimbursement for those people whose incomes were greater than 133% of the standard state welfare grant."[15] And Florida just got around to expanding the categorical eligible to include the medically needy at the 133% level at the late date of 1986.

"Though Medicaid had originally seemed to promise that everyone who needed medical care would be able to pay for it, the states were not eager to create the necessary programs while Congress was unwilling to kick in the money."[16] Florida did not join the Medicaid program until a skeptical legislature acquiesced by committing $43 million dollars to seven services required under the law for federal participation. This program began on January 1, 1970, delivering services to 307,687 recipients.[17] Seventeen years later the program's services have increased to 24, 10 of which are now mandatory. The striking figures are that the numbers of eligibles have increased over the past two decades by only 225,313 individuals, while the annual expenditures have ballooned from $43 million to $1.3 billion. Moreover, physician services account for only 4.6% of services delivered under Medicaid. Physician fees have not been increased in the Medicaid program since 1970, and only 35% of Florida's licensed physicians participate in the program. Medicaid reimbursement of physician fees is set at approximately one-half of Medicare fees.[18] The bottom line of all this is that Medicaid has not developed into a program that can remotely be considered as one that focuses on creating a public/private partnership for the delivery of medical services to program eligibles on an outpatient basis. And Medicaid is a program that at least has some money, albeit very little for physician services. What about providing services for the non-Medicaid and otherwise uninsured indigent who have no coverage?

Non-Medicaid indigents ● The FMA Symposium on Indigent Care held in November of 1986 demonstrated that with regard to indigents there are essentially three types that can be identified: (1) Medicaid eligibles; (2) the uninsured and unemployed non-Medicaid eligible; and (3) the uninsured and employed non-Medicaid eligible. As Florida grapples with the indigent care problem it becomes increasingly clear that public policy will have to direct its attentions to the non-Medicaid eligible population who number approximately 1.3 to 1.6 million persons at or below 150% of the federal poverty level. This includes those whose incomes are sufficiently high to classify them as being "medically indigent."

The much larger numbers of non-Medicaid indigents and the costs of institutional care experienced in Medicaid make it an absolute necessity that if the State of Florida plans to tackle the problem of the non-Medicaid indigent, it must do so by learning from Florida's history with Medicaid. The numbers virtually speak for themselves, and stand as arguments in support of an indigent care program built upon the FMA's 1985 policy statement: (1) broad based revenue funding source or sources; (2) a coordinated

Table 1. — Projected Medicaid Services and Expenditures in Florida, Fiscal Year 1986-1987.



Projected Expenditures = $1,329,187,356

Mandatory Services	Expenditures
Inpatient Hospital Services	$329,367,941
Outpatient Services	58,500,276
Rural Health Clinic Services	866,508
Laboratory and X-Ray Services	1,965,639
Skilled Nursing Home Care Services	67,230,497
Home Health Services	14,191,759
Early and Periodic Screening Diagnosis and Treatment (EPSDT)	14,423,192
Family Planning Services	1,532,998
Physician Services	60,716,362
Transportation Services	9,518,543

Optional Services	Expenditures
Prescribed Medicine	$116,257,447
Intermediate Nursing Care	358,524,476
State Hospital Services	8,241,482
Intermediate Care Service for the Mentally Retarded (ICP/MR)	126,272,371
Advanced Registered Nurse Practitioner Services	227,445
Dental Services for Adults	3,396,527
Visual Services for Adults	2,005,014
Hearing Services for Adults	977,293
Community Mental Health Services	11,533,680
Adult Day Health Care	1,919,059
Podiatry	*
Ambulatory Surgical Center	*
Birthing Center Services	15,600
Hospice Services	3,583,514

Notes: Home and Community-Based Services ($29,665,977); Prepaid Health Plan/HMO Service ($59,038,214) and Medicare Insurance Benefits ($49,215,542) are not shown as service programs as these are administrative mechanisms for delivering the above listed activities.

* Expenditures are not separately budgeted and are included in other service entities.

Source: "The Florida Medicaid Program: An Overview," Prepared by the Office of the Deputy Assistant Secretary for Medicaid, Department of Health and Rehabilitative Services, December 2, 1986, p. 7.

public and private sector provider system; (3) the inclusion of independent practitioners; and (4) emphasis on primary care and preventive medicine.

The linkage of these principles can occur in a variety of delivery mechanisms. Florida is uniquely blessed with a public health system consisting of 67 county public health units that began with the County Public Health Unit Enabling Act of 1931.[19] This act was strengthened by statutory language providing for primary care in 1983 and initial funding of $10 million in the Health Care Access Act for the delivery of primary care through county public health units.[20] Such contracting has been made with elements of the private sector and other public providers. Services are provided to the non-Medicaid and Medicaid eligible indigent and medically indigent. Approximately 80% of the patients receiving care from the health departments are non-Medicaid eligible.[21] This $10 million is of course a sparse amount when compared to the $1.3 billion Medicaid budget.

The question on the future agenda of the Florida Legislature is whether it will commit funds to a statewide indigent care program; and, if so, will funding expand exponentially as it did for Medicaid? Will most of the funds go for costly inpatient care? Or will public health, preventive medicine, and primary care have the opportunity to join the public and private sectors of medicine in community programs by county or multi-county configurations focusing on community health, health education, outpatient care, and applied epidemiology?

These same questions have been raised by others and answers to them form the crux of the Community Oriented Primary Care (COPC) programs sponsored by the Robert Wood Johnson Foundation.[22] COPC programs have been associated with the community health center movement throughout the United States and are the subject of a vast amount of study as viable approaches to the problem of indigent care.

A community approach linking the highly trained epidemiological and preventive medicine expertise of county public health units is one of several programmatic designs to find its way into legislation filed with the Florida Legislature during the 1986 session.

Legislative activity during 1986 ● The stimulus for addressing the problems of providing health care to indigents in Florida originated in the Health Care Access Act of 1984, which declared that "access to adequate health care is a right which should be available to all Floridians." The Legislature further stated "that unreimbursed health care services provided to persons who are unable to pay for such services cause the cost of services to paying patients to increase in a manner unrelated to the actual costs of services delivered."[23]

During the months leading up to and including the April, May and June session of the 1986 Florida Legislature, the FMA participated in several legislative hearings held around the state by the Indigent Care Task Force of the House of Representatives Committee on Health Care and Insurance. Similarly, the FMA presented testimony before the Florida Senate in its deliberations on the subject of indigent care. Generally, such testimony was made to espouse the principles set forth in the FMA policy statement, and how the various legislative proposals being heard were consistent or contrary to those principles.

There were several major bills on indigent care filed in the Florida Legislature in 1986. The first bill introduced was by Representative Tom Woodruff, R-St. Petersburg.[24] Representative Woodruff's bill would have created a State Insurance Program to be administered by geographical brokers in five areas of the state. The bill's major characteristic was that it called for broad based funding of indigent care by replacing the hospital tax with an increase of one-half percent in the state's sales tax. The tax would have generated, according to estimates, a sum of $500 million. The bill died in committee.

Another major legislative proposal was filed by Representative Mike Abrams, D-Miami, which passed the House during the last days of the session, but did not come up for a vote in the Senate.[25] This bill called for nine demonstration projects for the provision of services to the indigent. Seven of the demonstration projects called for the establishment of prepaid services to 1000 non-Medicaid eligibles each. Four of these seven projects were mandated to be tied to four of the existing comprehensive prepaid Medicaid plans at Mt. Sinai Hospital and Jackson Memorial Hospital in Miami, the Palm Beach County Public Health Unit in West Palm Beach, and University Hospital in Jacksonville. Two of the seven projects were to be in rural areas not currently served by a prepaid Medicaid plan. The contractor for these rural demonstrations would have been required to provide prepaid services to 1000 non-Medicaid eligible indigents also, and at the same time develop comprehensive prepaid Medicaid plans. The seventh project called for a prepaid non-Medicaid and prepaid Medicaid enrollment plan in an area with a high percentage of racial minorities.

The remaining two demonstration projects in the Abrams' bill, which brought the total to nine, would have expanded the primary care programs currently being delivered in 18 counties through county public health units to Bay and Orange Counties. One million dollars would have been allocated to the Orange County Public Health Unit and $500,000 to the Bay County Public Health Unit. The programs would not have been prepaid, and by design would have built upon the county public health unit as provider and broker of indigent care to private and other public providers where appropriate and available. The new funding for these two primary care projects would have increased the amount of money designated

for primary care through county public health units from $10 million per year to $11.5 million.

A third major bill was filed by Representative Alzo Reddick, D-Orlando, and later co-sponsored by Representative Woodruff.[26] The bill was heard in the task force hearings of the Committee on Health Care and Insurance, but did not reach the floor of the House. It was directed at establishing a statewide mechanism to meet Florida's significant indigent health care needs. It proposed to establish an indigent care program by expanding county public health unit primary care services to all 67 counties of the state. Each county public health unit would serve as the broker, that is the entity responsible for assuring that indigents receive primary care, secondary care, and hospitalization as may be necessary, on a contractual arrangement with various health care providers available within a county or contiguous geographical area. This contractual or fiduciary relationship among the health units with indigent patients called for a strong relationship between the public and private sectors of medicine. It thus did not rely upon any one specific delivery or financing mechanism; rather, it embraced a pluralistic approach by which the health unit could contract with fee-for-service solo practitioners, IPAs, HMOs, PPOs, or other alternative arrangements, including federal primary care centers.

The Reddick legislation would have increased the funding of primary care through county public health units by an additional $20 million for a total of $30 million statewide to expand the primary care program to all counties. It would have created a Non-Institutional Provider Trust Fund within the Department of Health and Rehabilitative Services to increase the reimbursement of certain Medicaid services as follows: an additional $11.5 million for physician services; $4.4 million for dental services; $900,000 for early periodic screening, diagnosis, and treatment services (EPSDT); and $700,000 for home health services. This bill also made provision for inpatient and emergency room services to be paid from the Public Medical Assistance Trust Fund. The bill encouraged private sector participation by calling for extension of the state's limited sovereign immunity to cover physicians licensed under Chapters 458 and 459, Florida Statutes, who contract with county public health units to provide care to indigents. When providing care to indigents, such physicians on contract would be serving as agents of the state.

In the Florida Senate a bill was sponsored by Senator Roberta Fox, D-Miami, and Senator George Stuart, D-Orlando, which combined Senator Fox's version of Representative Abrams' bill and Senator Stuart's companion bill to the Reddick bill.[27] The bill was voted on favorably by its several committees of reference and was on the Senate calendar when the Legislature adjourned.

The Florida Medical Association testified in support of Representative Reddick's House bill, which called for a statewide public and private partnership for the provision of indigent care services, as well as its feature pertaining to primary care and preventive medicine, Medicaid provider reimbursement enhancements, and extension of the state's limited sovereign immunity to physicians providing services to indigents on a contractual basis with the state's county public health units. Similarly, the FMA supported those same elements in the Senate bill companion by Senator Stuart.

Apart from this legislative activity, the FMA had ongoing dialogue with the Florida Hospital Association, Florida League of Hospitals, Florida Voluntary Hospital Association, other provider associations, and the State Association of County Commissioners, all of whom were involved in the many deliberations on indigent care conducted throughout 1985 and 1986. The FMA appeared before the indigent care task forces of the Hospital Cost Containment Board and the Statewide Health Council. Throughout, it became evident that the issues of financing and the organization of a statewide indigent care program were filled with complexities, diverse interests and perspectives, and a general lack of consensus on how best to meet Florida's indigent care situation.

FMA Committee on Indigent Care • In September of 1986, the Florida Medical Association established the Committee on Indigent Care within its Council on Medical Economics. The Committee on Indigent Care consists of 11 physician members, and advisors from other health care provider associations and the Florida Legislature.[28]

After reviewing the activity on indigent care by the FMA and other interested parties, the Committee on Indigent Care made the following recommendations that were subsequently approved by the Board of Governors: (1) continue to support a broad based funding approach for the financing of indigent care, as well as a primary care and preventive medicine delivery system that emphasizes the coordination of public and private sector services to indigents; (2) seek enactment of legislation providing for county public health units to serve as brokers of indigent care to the private sector with provisions for appropriate alternative brokers; and (3) seek enactment of legislation that will include the extension of the state's limited sovereign immunity to cover physicians providing care to indigents on contract with county public health units and all physicians providing care to indigents through state and/or federally funded mechanisms.

The Committee next sought input from public and private sector experts on indigent care. These included representatives of the Florida Department of Health and Rehabilitative Services (HRS), who gave an in-depth presentation on indigent care in Florida, the status of Florida's indigent population, and the levels of income constituting poverty, 133% of poverty, 150% of poverty, on up to 200% of the poverty level.

This presentation elucidated the sizeable problem Florida faces in terms of instituting an indigent care program at various income levels and the comparatively poor ranking Florida has in per capita expenditures on health programs.

Officials of the Center for Health Policy Research, University of Florida, discussed with the Committee the inpatient indigent care study conducted by the Center on contract with the Florida Hospital Cost Containment Board in 1985-86. Of particular significance in this discussion was the observation that the data from the inpatient study showed that the primary source of uncompensated and indigent care in terms of admittance to hospitals comes from the utilization of hospital emergency rooms. This fact gives support to the FMA's approach that emphasis should be placed on primary care and preventive medicine in order to obviate the need for emergency room use and otherwise preventable hospitalization through intervention before or during the early stages of the disease process.

The Committee also reviewed the features of a study on outpatient uncompensated and indigent care, which is being conducted by the University of Florida on contract with the FMA. According to the University of Florida, this is the first study of its type in the nation. The survey results of 6,500 physicians in Florida should be available during early Spring of 1987. The purpose of the survey is to elicit information on the amount of indigent care services being provided by physicians in Florida, and to translate those services into estimated costs of uncompensated care. From this data, it is hoped that a more complete picture of the costs of a State of Florida indigent care program can be produced for the state legislature.

Agenda for the future • Time and the political process will ultimately determine the details of a Florida indigent health care program. What the FMA has brought to the attention of those involved in the deliberations on this issue, as well as to its own membership, is that within the house of medicine there exist a private sector of dedicated physicians and a cadre of public health physicians who truly believe that together they can work to meet the health care needs of Florida's indigent population. Their shared approach merits serious consideration by the Florida Legislature.

The State of Florida simply cannot afford a Medicaid type of program for the rest of its indigent and medically indigent population. Regardless of the details of a Florida indigent care program that may ultimately be enacted, the experience with Medicaid provides the fundamental lesson that physicians must play the key role in the provider system in order to diminish the need for costly institutional care. Combined with the range of preventive, public health, and other community oriented programs, the overall health status of the indigent population then can be improved for the betterment of society as a whole. The agenda for the future of indigent care in Florida must never lose sight of that ultimate objective. And physicians desirous of assuring that all Floridians do in fact have a right to access our health care system should bear in mind the inscription on the lamp outside the jungle hospital of Albert Schweitzer, M.D., at Lambaréné, Africa: "Here, at whatever hour you come, you will find light and help and human kindness."

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28. The membership of the Committee on Indigent Care: Charles B. McIntosh, M.D., Chairman, Jacksonville; Charles P. Hayes Jr., M.D., Vice Chairman, Jacksonville; Jacques R. Caldwell, M.D., Daytona Beach; James K. Conn, M.D., Tallahassee; T.M. (Dan) Daniel, M.D., Clearwater; Richard S. Hodes, M.D., Tampa; Husman Khan, M.D., Lauderhill; Jack W. MacDonald, M.D., Tallahassee; John F. McGarry, M.D., Orlando; and Donald G. Nikolaus, M.D., Dunedin. Advisory members to the committee are: Senator George Stuart Jr., D-Orlando; Rep. Alzo J. Reddick, D-Orlando; John McBryde, President of the Florida Hospital Association; and Kerry E. Kilpatrick, Ph.D., Director of the University of Florida Center for Health Policy Research. FMA President James B. Perry, M.D. serves as the FMA Board of Governors liaison to the committee.

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The nature of the indigent care problem in Florida

Kerry E. Kilpatrick, Ph.D.

The following comments mirror my remarks as an introduction to the FMA sponsored symposium on Indigent Care held in Tampa on November 24, 1986. As such, they are meant to set the stage for the more definitive papers that follow and do not fully articulate potential solutions to the problem.

Concern for the provision of health care services to the indigent is, of course, not a new phenomenon in this country. The development of the system of hospital care in the United States can trace its roots primarily to philanthropic concerns for caring for those unable to pay. Explicit public policy in support of health care for the poor and especially the elderly was articulated at least as far back as the Social Security Act of 1935, the Hill-Burton legislation of 1946, and extended through the enactment of Medicare and Medicaid in 1965 through the present day where we are enmeshed in a complex system of programs at the federal, state, and local level attempting to meet the problem of providing health care to the poor.

What causes indigent care to be a particular problem today is a confluence of a number of forces in American society. All of these forces have been changing slowly over a long period of time. The magnitude of the indigent care problem is now so great that legislative leaders at the state and federal level characterize indigent care as the most pressing and most difficult problem they face.

Not less than 36 state governments have taken some action on the problem, as have countless local units (typically counties). Congressional concerns were addressed in the SOBRA legislation in 1986; further activity will undoubtedly unfold in this congressional session as well. This attention has been directed primarily toward the provision and costs of inpatient hospital services, but that emphasis tends to understate both the magnitude and the complexity of the problem. Clearly, ambulatory medical care, mental health services, preventive care, long term care, and other health services sectors also bear a portion of the burden from patients who cannot pay.

Two of the driving forces that cause indigent care to take on a special urgency today are most important. The first is the increasing emphasis on the use of "market forces" to contain health care costs. Although care to the indigent has been partially supported through a variety of governmental programs, a large and hidden portion of that care was traditionally borne by providers who gave free or reduced charge care. In the past, providers shifted the charges for indigent care to those who were able to pay. While charge shifting was never totally fair, it is now becoming increasingly less feasible as the purchasers of health care services have become unwilling to pay for costs not directly attributable to care provided to their own subscribers. The prices negotiated by HMOs, PPOs, and other managed care alternatives do not contain allowances for the poor.

The second force is political. Governments at all levels are facing demands by taxpayers to decrease or, at least, not increase taxes. This reality, coupled with health care costs that continue to escalate at twice the rate of general inflation in spite of efforts to contain costs and a growing number of individuals who are not covered by any form of health insurance, means that governmental programs cannot maintain

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the levels of service of even a few years ago. The results of this situation are seen in cut backs in Medicare and Medicaid coverage, means-testing for Veterans health care, and a growing reluctance of state and county governments to shoulder more of the burden of health care for the poor.

In Florida, the indigent care problem is exacerbated by a number of features of the state's population and economy. First, Medicare, as by far the largest payor for hospital care, is more dominant in Florida than elsewhere. As Medicare reimbursements are restricted, the burden must be placed on other sources of funding — sources which in Florida are proportionately smaller to begin with. Second, Florida's employment structure in agricultural, seasonal, part-time and service industries results in lower proportions of the state's employed population having health insurance coverage than in other parts of the country. Third, Florida's Medicaid program is one of the least generous in the nation. Finally, this state's health services industry is among the most competitive in the country. Of the half-dozen most populous states, Florida's HMO enrollment is the fastest growing. Florida also has more than four times the national average of investor owned hospitals — over 40%. These hospitals operate under much different incentives and constraints than the public hospitals that are the traditional providers of indigent care.

Recently there has been considerable attention devoted to analysis of the indigent care problem and, in particular, the problem of uncompensated care in hospitals. Much of this attention has been directed to the magnitude and distribution of hospital uncompensated care by hospital type and ownership. Except for examinations of individual hospitals, little has appeared in the literature that describes the characteristics of the patients who are responsible for uncompensated care. As the Health Economist, Gail Wilensky, has noted, "[u]nfortunately, there is a paucity of direct information about the characteristics of individuals who generate uncompensated care." Paul Duncan's paper which appears in this issue, examines new findings about indigent care in Florida's hospitals.

Magnitude of the problem in Florida • Dealing effectively with the problem of provision of health care to indigents requires an understanding of the current magnitude of the problem. Solutions that address only a piece of the overall situation, however well-intended, may at best be temporary "band-aids." At worst, if the effects of attempting to fix only one facet of the problem are not understood, some "solutions" can serve to exacerbate the present situation. The Health Care Access Act of 1984 was a "band-aid." Relative to the scale of the problem, state support for indigent care was not significantly enhanced by the Health Care Access Act. Fortunately, county governments, hospitals, and physicians have recognized that more effective solutions are needed and have not diminished their current level of support of care for the indigent. If providers and counties were to reduce their support without adequate new funding, the effect would be disastrous.

There are three ways to measure the magnitude of the indigent care problem. The first is to attempt to quantify the unmet "need" for health care services in the state. The second is to attempt to put a dollar figure on the volume of services currently being delivered to indigents. Any reduction below this dollar level would in all probability reduce services delivered. Third, one could quantify the number of persons residing in the state who have inadequate financial means to meet their health care needs and would require some public assistance in the case of a health care emergency.

Florida has never undertaken the kind of careful assessment of the need for health care that would permit a meaningful quantification of "need." As the state is unlikely to support such an assessment in the near future, indirect means of quantifying the problem must be used.

A reasonable estimate of the dollar magnitude of the problem is shown in Table 1. Considering all sources (federal, state, county, and private), currently $2.8 billion are expended annually in Florida for indigent care. Thus, an increased state general revenue contribution of $20 million or an assessment on hospitals yielding $100 million, as in the Health Care Access Act, while commendable, falls far short of even addressing the current uncompensated care problem of health care providers let alone making impact on unmet needs.

Estimates of the number of indigent persons in Florida vary. According to a 1985 study done by Louis Harris for the Department of HRS, there were 4.25 million persons living in families with incomes at or below the federal poverty level of $15,915 for a family of four. Because the income levels for state Medicaid are pegged to the AFDC standard of $3,408 for a family of four, 3.2 million of these persons did not qualify for Medicaid even with the expanded program in 1985. The 1986 expansions will move the income standard to 133% of the AFDC standard or $4,544. The expanded medically needy program is expected to cover an additional 178,000 persons. This may, in fact, be an over-estimate of actual enrollment however. The 1985 expansion was estimated to attract 51,000 individuals whereas only 1,200 actually enrolled.

By any measure then, the indigent care problem in Florida is a large one. While this appears superficially obvious, the true scale of the resource requirements to address adequately the problem should be kept in mind as proposed solutions are evaluated.

General strategies: general policy options to resolve uncompensated care • While there are a great

Table 1. — Estimated Cost for the Care of the Medically Indigent.

Counties (1)	$190.60
Hospital Tax Districts (1)	45.00
Medicaid — State (2)	566.20
Medicaid — Federal (2)	720.60
Hospital Charity Care and Bad Debt (3)	831.00
Physician Provided Indigent Care (4)	——
HRS Indigent Care Programs (2)	
ETOH/Drug Abuse/Mental Health Services	174.50
Health Services (excludes approps to local aid)	47.90
Aging and Adult Services	10.40
Children's Medical Services	84.30
Developmental Programs	0.32
Economic Services (for eligibility determination)	27.70
TB Hospitals	7.80
Department of Education Funds (2)	
Shands Contract	10.00
State General Revenue	10.00
Hospital Assessment	
Undisbursed Cash Balance	120.00
Total	$2,846.32

1. Jones, Katherine R. and Elizabeth McCulloch, Study of Delivery of Health Care to the Indigent: Final Report, Center for Health Policy Research, University of Florida, February 28, 1986. County contributions include county indigent program, public health department, and contributions through the Health Care Responsibility Act. Counties also contribute $39.5 million to Medicaid — this is included in the Medicaid totals.

2. State of Florida 1986-87 General Appropriations Act and Summary Statement of Intent. Figures include state, federal, and residual county funds.

3. Total charity care and bad debt estimated by HCCB for 1986 is $831. Bad debt includes uncollected accounts for persons who are able to pay. No estimate of proportion of bad debt that is true charity care is provided.

4. Estimates of indigent care provided by physicians are not yet available.

variety of specific proposals that have been advanced to address the problem of uncompensated care, the proposed solutions can be grouped into one of the following four categories:

1. Do nothing. That is, continue to force providers to shift charges from those who cannot or will not pay to those who do in the form of a "sick tax." As both government and private payors move toward fixed, prospective pricing there simply will not be anyone left to shift charges onto.

2. Target providers. Physicians, hospitals, and other providers could be compensated directly if they provided a greater-than-average share of uncompensated care. The Health Care Access Act of 1984 had such a plan as a goal for hospitals; it has yet to be implemented.

3. Target individuals. Medicaid does this. Other options would be to provide catastrophic or other types of health insurance to those who are unable to afford insurance without public assistance.

4. The State could make direct grants to governmental units (e.g., counties) and permit these units to tailor programs to their individual circumstances. Under such arrangements counties would be free to develop capitated plans, competitive bidding for services, local outreach clinics, or augmentation of existing fee-for-service systems.

Each of these four options has both technical and political strengths and weaknesses. None exists in any state in a pure form. In Florida, as elsewhere, the eventual solution will likely be an admixture of all four options.

Solutions from other states • Given the current political climate at the national level, and the mandate to reduce the federal deficit, there is little likelihood that federal actions will be undertaken to provide a comprehensive solution to this problem. Recent proposals emanating from both the Adminstration and from Congress suggest that Washington is quite willing to leave the funding of indigent care to the states. Furthermore, the variability of the indigent care problem, as it is manifested in different geographic regions, suggests that no single solution exists. Hence the issues will be addressed (if anywhere) at the state level.

During the last two or three years, at least 36 states have initiated some activity in the area of indigent care. These activities range from modest (e.g. single legislative committee hearings) to fully developed legislative proposals or enactments. The actions in most states include one or more of the following:

1. Modification (usually to expand eligibility) of Medicaid programs.

2. Creation of state-only indigent care programs which are intended to support the provision of services to persons who are ineligible for alternative assistance programs such as Medicaid.

3. Augmentation or enhancement of county programs, including administrative support and assistance in the event of catastrophic expenditures by a county.

4. Efforts to ensure that hospitals either provide some level of charity care or provide financial support to those institutions who do provide such care.

5. Efforts to increase the role of private insurance, and the number of people who have adequate coverage.

6. Demonstration projects intended to make state governments more effective purchasers of health care services, and hence able to support the provision

of more services at any given level of expenditure.

7. Exploration of alternative revenue sources to support whichever combination of the preceding is deemed appropriate in any given state. Those typically emphasize one of three alternatives — general revenue (state, property or income taxes), sin taxes (cigarettes, alcohol, etc.) or health care sector taxes (hospital assessments, insurance premium taxes).

Moving toward a solution • The other papers in this issue suggest a number of alternatives to address the indigent care problem in Florida. Each author provides new insight into the nature of the problem and what solutions should be investigated.

While it is still too early to tell what proposals will eventually prevail in the 1987 legislative session, there is a growing sense of urgency among health care providers that some definitive steps must be taken this session. Further, broad outlines of consensus of what should be done have emerged.

First there is general agreement that it is inappropriate to require the health services industry to bear an unreasonable level of uncompensated care, thus perpetuating the charge shift. Broad based revenues should be sought to fund indigent care. Sources that are currently being proposed include a dedicated increase in the state sales tax, increases in taxes on alcohol and tobacco, increases in the corporate income tax, a dedicated ad valorem tax, and increases in beverage license fees and professional and occupational license fees. There is, among organizations representing providers, a consensus that funding indigent care through a "sick tax" of any kind is not acceptable as it will continue to shift charges to an increasingly smaller group of patients who pay full charges.

A second principle that has general acceptance is that the primary care component of the health services delivery system in Florida must be enhanced and expanded. This includes expanding the state primary care program to all 67 counties. It also would call for a significant increase in Medicaid fees for physicians to at least the fiftieth percentile of Medicare fees. Further, encouragement for physician provision of primary care to indigent patients would include extension of sovereign immunity to the provider of care for these patients.

It is now generally recognized that a large number of persons who cannot pay their doctor or hospital bills are either employed or recently unemployed but do not carry adequate health insurance. A third principle recognizes that the state can alleviate this problem in a number of ways including facilitating the organization of "synthetic groups" of small employers and subsidizing the premium on a "bare bones" health insurance policy for persons who otherwise qualify but lack the economic resources to pay for coverage. Pilot projects in defined geographic areas could be undertaken to evaluate the feasibility of insurance-based solutions.

Fourth, in order to maximize the use of matching federal dollars, the Medicaid program could be expanded in a number of significant areas. These include elimination of the outpatient cap, expansion of the improved pregnancy outcome program, and developing new maternity and pediatric eligibility options. Expansion of the Medicaid program should come from state general revenue and matching federal dollars not from increased assessments on providers.

Finally, there is strong support for developing a mechanism to disperse the cash surplus in the Public Medical Assistance Trust Fund (estimated to reach $180 million this year) to providers who can document that they provide a disproportionate share of free care to indigent patients. The precise features of such a distribution system will need to be worked out in the coming months.

These are some of the general concepts that appear to have broadbased support. The 1987 legislative session promises to offer a rich menu of indigent care alternatives for debate and consideration.

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National overview of critical indigent care issues

Gloria J. Bazzoli, Ph.D.

Indigent care is becoming a critical problem across the United States. In order to present a national perspective, I would like to summarize the key points of an article I wrote on the topic.[1] Existing literature on indigent health care was reviewed to determine the questions answered by prior research and those yet to be resolved. Research was specifically examined in four different areas:

1. Studies of the size and characteristics of the indigent population.
2. Analyses of public programs that provide or fund care for the economically disadvantaged.
3. Studies of the providers of health care to the poor.
4. Examinations of the impact of structural changes in the health care sector on the provision of charity care.

Profile of the indigent population • When considering the profile of the indigent population, it is important to realize that identification of this group is a very difficult task. Studies examining the characteristics of indigents tend to focus on individuals who lack health insurance coverage and also, more recently, on those who have inadequate health insurance. Uninsured and underinsured individuals clearly are likely to become indigent if an illness occurs. However, we do not know how many of these individuals experience difficulties obtaining or paying for care at any point in time. All we know is that they are at higher risk of having these types of problems.

With this caveat in mind, let us consider what the existing literature tells us about the size of the population at risk of indigency. My review indicated that in 1982, the year for which the most data are available, around 22.4% of the population under age 65 were at risk, either because they were uninsured, underinsured, or otherwise medically disadvantaged. If this percentage is applied to population figures for 1985, one obtains an estimate of about 47 million individuals under 65 at risk of indigency. This figure may be high, though, since 1982 was a recession year. However, more recent data indicate that the percent of individuals without insurance has not fallen between 1982 and 1985; thus, the 47 million figure seems to be an acceptable benchmark. Of these 47 million individuals, 28 million (56.4%) were poor or had income just above the poverty line. These 28 million individuals are particularly vulnerable to indigency given their limited resources. For them, even a minor injury or illness could be a major problem.

Population groups over-represented in the ranks of the potentially indigent include the poor, individuals from families whose primary wage earner is unemployed, and those from racial or ethnic minority groups. In addition, those at risk tend to be young, primarily age 19 through 24. But children age 18 and under have a special problem that is not apparent from statistics on the characteristics of the at risk group. An alarming number are uninsured even though they live with insured parents or guardians. In 1982, 4.1 million children lived under these circumstances. Apparently, a number of families cannot afford dependents' health insurance.

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Major public programs • The second part of my review research article presented an examination of public programs developed for the economically disadvantaged. Federal, state, and local governments have been active in this area. Of the different initiatives, Medicaid, authorized under Title XIX of the 1965 Social Security Administration Act, is by far the largest and most well known. This program is very diverse since the federal government gives states great flexibility in program design. Despite diversity, Medicaid has been effective at improving access to care among program participants, but this success came at great cost to the federal government and the states. Medicaid expenditures rose by about 14% per year for every year after 1975, even though the number of Medicaid recipients stabilized.

Needless to say the Reagan Administration has sought ways to reduce federal commitments to the Medicaid program for several years. The Omnibus Reconciliation Act of 1981 was a step in this direction, although it provided the federal government with only temporary relief. Under the guise of the new federalism, this Act gave states increased leeway in limiting their Medicaid programs so that they could in turn reduce their Medicaid expenditures. As a result, many states cut Medicaid programs; Florida was one of 30 states to do so. In 1981, states viewed Medicaid expenditures as a drain on their resources. However, as the economy improved in late 1982, several states renewed their commitments to Medicaid and some even expanded their commitments beyond pre-1981 inflation-adjusted levels. States began to realize the power of their Medicaid dollars since each dollar translates into at least two after federal matching payments. As a result, state and federal expenditures for Mediciad have accelerated in the past few years.

With the current state of the federal budget, pressure to limit Medicaid expenditures will grow. For the past two years, the Reagan Administration proposed a cap on federal Medicaid payments. Although federal caps have not been adopted, they may become more palatable to legislators as the federal budget mess continues.

Besides Medicaid, the federal government has an array of other programs that provide health care to the disadvantaged, primarily in the form of block grants to the states. These include: Maternal and Child Health Services Block Grant; Preventive Health and Health Services Block Grant; and Primary Care Block Grant.

All programs funded under these three block grants have existed since the 1970s. However, prior to the Omnibus Budget Reconciliation Act of 1981, all were federally administered. With passage of the Act, authority passed to the states, and federal expenditure levels declined by about 25%. Thus far, it has been safer politically to limit expenditures on health block grants than to reduce Medicaid payments. Cutbacks in health block grant funding should be expected to continue.

Besides federal initiatives to help meet the health needs of the disadvantaged, several state and local governments have developed their own programs. In all, there have been five major types of activities. First has been development of state and county indigent health services programs that reimburse health providers for care rendered to certain Medicaid-ineligible population groups. A second type of state/local action is financial support to hospitals that provide substantial amounts of uncompensated care, with the funds for this support coming from tax-generated indigent care pools, all payer hospital rate-setting programs, and/or direct financial support of public hospitals and clinics. A third action has been passage of insurance legislation that increases availability of health insurance covering large, unanticipated medical expenses. Examples include catastrophic health insurance coverage, insurance pools for individuals of high medical risk, and minimum benefit standards for health insurance plans. Finally, several states are studying indigent care problems to develop recommendations on health care provision and financing. Many have appointed special task forces to undertake this activity, and a few have conducted special surveys of patients and hospitals similar to the Florida hospital studies.

Thus, states and local governments have responded in a variety of ways to indigent health care problems. Their involvement will have to continue, and most likely increase, given the smaller role that the federal government will take.

Providers of care to the indigent • The third area I examined in my research was national studies of the providers of care to the indigent. The literature suggests that uncompensated hospital care tends to be highly concentrated. National data show that public, teaching, and urban hospitals tend to have a disproportionately large share of uncompensated care relative to their share of total beds. Several studies indicated that hospitals providing high levels of care to the poor are more often financially stressed. As a result, many have been forced to limit charity care activities.

Very little data are available on physician provision of charity care. In 1982 the American Medical Association asked about 1,000 physicians across the country to report the amount of free or reduced fee care they provided to patients who lost health insurance coverage. AMA estimated from the data that about 5% of a physician's gross annual billing went toward care of these patients in 1982. Overall, then, about $6.2 billion of free or reduced fee physician care was provided to patients who lost their health insurance. However, this estimate is likely to be inaccurate since the AMA data has several shortcomings. The Florida Medical Association study of physician

uncompensated care will provide much precise information. Since these data will be unique, they will have major ramifications across the nation.

Impact of structural change on indigent care • The final area I examined was the impact of structural changes in the health care sector on indigent care. For this section, research findings were needed on the charity care effects of hospital closings, consolidation, and specialization, and the effects of development of prospective pricing and preferred provider networks. Unfortunately, little research has been done; the needed data have not yet been assembled. Much speculation exists and, interestingly enough, there is little disagreement in this speculation. All health care experts believe that increased competition and increased cost pressures will only make it more difficult for hospitals and physicians to provide charity care.

Conclusion • My review of the research literature indicated that the problem of indigent care is large and growing across the United States. A myriad of health programs exist but their level of funding has fluctuated over time. To a large extent, these programs have helped the needy gain access to care; however, many individuals continue to rely strictly on the generosity of a small number of providers. The economic pressures on these providers as well as structural changes occurring in the health care sector can only have an adverse effect on the amount of charity care that can be extended.

The federal government has and will continue to limit its role in the indigent care problem. The new federalism has already left a large number of needy individuals without a safety net. For each poor individual currently covered by Medicaid there are three others who are not. Yet, during the heyday of Medicaid, nearly all those individuals with incomes below the poverty line were covered. I believe that only through the combined efforts of state and local governments and the private sector can we hope to fill the tremendous gap created by the deterioration of the federal role in care for the economically disadvantaged.

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How to finance indigent care: framework for the debate

Douglas E. Hough, Ph.D.

My purpose is to provide a context for discussing how health care for the indigent should be financed in Florida. That is, I have the unenviable task of talking about taxes. I hope that this sometimes arcane presentation will place the debate over financing indigent care within the framework and traditions of American tax policy.

Principles of public finance • Taxation in this country has long been guided by four major principles:

1. Efficiency: Any tax should minimally disrupt productive economic activity.
2. Equity: The tax burden should be distributed equitably.
3. Incidence: Any shifting of a tax among potential taxpayers should not undermine the tax's intent.
4. Cost: A tax should be economical to collect.

Although each of these principles is unobjectionable, all are rarely achieved by any one tax. As a result, tax policy in the United States has been forged by a kind of dynamic tension, with a continual shifting of support among the four principles. Thus, any discussion of financing health care for the indigent in Florida must be considered within the context of these principles.

Efficiency • Unfortunately, the cost of taxation is not limited to the amount of revenue extracted from taxpayers. A tax on any activity — the purchase of a good or service; work; investment — makes that activity more expensive and, thus, lowers the demand for it. By so doing, the tax distorts normal economic enterprise and creates an "excess burden" beyond the actual payment of taxes. The U.S. tax system (national, state, and local) has created a total excess burden estimated to equal 30% of tax revenue, or 10% of gross national product. That is, were there no tax system at all in this country, GNP would be 10% higher than it is today.

The goal, then, is to structure a tax to minimize its interference with economic decisions made in otherwise efficient markets. In general, this excess burden is lowest for taxes on those activities that taxpayers will continue doing even if a tax is placed on it: head taxes imposed on all citizens uniformly, regardless of economic activity; taxes on necessities or goods for which there are few substitutes, e.g., food, health care and broad-based taxes; which create a uniform distortion on all taxed activities. An exception to this goal occurs when some taxes can be used to correct failures of markets and, thus, can actually reduce the excess burden of economic decisions; for example, a tax on polluters forces them to recognize the cost they impose on the rest of society and thereby improves the efficiency of the economic system.

A final point to note is the impact on economic efficiency of so-called "earmarked" taxes, that is, taxes whose proceeds are dedicated to a specific governmental use. Such taxes may create an excess burden by introducing rigidities into the budgeting process. For example, the earmarked revenue from an increase in a state sales tax to pay for new schools may be either insufficient or overgenerous, given other demands for scarce public funds. On the other hand, an earmarked tax, e.g., gasoline tax, may be equivalent

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to a fee charged to a consumer, thus mimicking the workings of an efficient market system.

Equity • The principle of tax equity implies that a tax be levied on those who "should" pay with equity being defined by two criteria. The "ability to pay" criterion asks: "Is the tax in question levied on those who can best afford to pay?" The tradition of American tax policy has held that those with higher income or wealth can better afford to pay taxes. The "fairness" criterion asks: "Is the tax levied so that taxpayers with 'equal capacity' pay the same?" Equal capacity has been variously defined by income, family size, economic handicap, or other social characteristics.

Contrary to this principle, most states have levied regressive taxes. For instance, Florida households with income less than $3,000 pay 13% of their income in state taxes. Conversely, Florida households with income greater than $35,000 pay only 4% of their income in all state taxes.

Incidence • Who ultimately pays a tax is not necessarily the same as on whom the tax is originally levied. The issue here is not illegal tax evasion or noncompliance but rather tax shifting or tax avoidance through legitimate means. To the extent that a tax can be shifted, such shifting can pervert the original legislative intent of the tax in terms of efficiency and equity. For example, it does not take a devotee of supply-side economics or other theories composed on cocktail napkins to realize that the federal income tax is not as progressive in practice as it is in statute; many of those with high incomes have been able to reduce their effective tax rate by sheltering substantial amounts of otherwise taxable income. In fact, this divergence between statutory and realized income tax rates was a major impetus for the recently passed tax reform legislation.

Shifting tax incidence is not limited to the federal level. Many state taxes are vulnerable to this phenomenon as well. For example, state sales taxes are levied on vendors; although they must collect the tax, vendors do not necessarily pay the tax. The extent to which they can, in fact, shift the tax to consumers depends largely on how sensitive consumer demand is to price increases.

Cost • The cost of collecting and administering a tax is not insignificant. It includes the costs of identifying taxpayers, printing and distributing tax forms, processing tax returns, and enforcing compliance to the law. In addition, taxpayers incur costs themselves in complying with the tax law, from maintaining records to preparing returns. As an example, the federal income tax — which is extolled as a model for tax collection efficiency — costs the government about $3 billion per year, or about ½¢ per dollar of revenue, to collect. By comparison, the State of Florida spends about ¾¢ per dollar of revenue to collect its state sales tax. However, individuals and corporations spend another $10 billion to comply with the tax, so that the total cost to society for collecting the federal income tax is 2½¢ per dollar of revenue.

In terms of this principle of taxation, increasing the rate of an existing tax is preferable to enacting a new tax to collect the identical amount of revenue. A new tax requires identifying new taxpayers, creating new forms and processing procedures, and establishing new compliance rules, whereas an increase in an existing tax often requires only distributing a new rate sheet.

Financing indigent care in light of these principles • The State of Florida has a variety of options for financing a program of health care for the indigent. It can use a broad-based tax. A one-half percent increase in the state sales tax would generate about $550 million of revenue per year. Or, it could impose a new personal or corporate income tax. Alternatively, the state could use a narrow-based, or targeted, tax. For example, it could raise about $700 million a year by repealing the sales tax exemption on health care services and products. Or, it could extend the current tax on hospital revenue to other health care providers. Or, it could tax health insurance premiums.

Each of these alternatives can be debated from numerous perspectives. I want to conclude by using the four principles of taxation that I have discussed to examine the arguments for and against a tax on hospital revenue to finance health care for the indigent in Florida. An equity argument in favor of such a tax is that the state, through its various licensing authorities, has granted hospitals a franchise to operate. As a result, hospitals have a responsibility to return something to society, e.g., to either provide or pay for indigent care. In terms of efficiency, it can be argued that without such a tax, the unencumbered health care "market" will fail to provide sufficient indigent care. Finally, proponents of a tax on hospital revenue could argue that such a tax would cost relatively little to administer, because hospitals are easy to identify and tax.

The opposing viewpoint can also be cast within this framework. An equity argument can be made that providing health care for the indigent is a societal problem and only one element of a more fundamental issue of society's responsibility to the poor. Thus, hospitals are inappropriate vehicles for financing a solution to a society-wide problem. From an efficiency standpoint, it can be argued that a hospital-based tax will distort prices in health care and lead to an inefficient allocation of scarce resources between inpatient and outpatient care and between health care services and the rest of the economy. Lastly, opponents can charge that such a tax will have perverse incidence effects. They can argue that a tax on hospitals will largely be shifted to patients and third-party payors in the form of higher charges. Thus, the health care

of the sick poor will be paid for by the rest of the sick population. If payors can shift the tax onto their policyholders, then the insured population will finance the health care of the uninsured. Such a result may not be unappealing. However, if such shifting takes place, it raises the question of why the tax is not imposed directly on the insured population (or the entire population of the state, for that matter), rather than relying on a cumbersome tax on hospitals.

Conclusions ● It may be frustrating that I do not intend to say which of these arguments I believe are most compelling. My purpose today, however, has been analysis, not advocacy. The debates that will occur during the next several months over how health care for the indigent in Florida should be financed will address a myriad of concerns and will be couched in multiple guises. My one strong recommendation is that the result of the debate adhere to the principles of American tax policy that have served this country so well. I hope that my presentation has elucidated these principles and will facilitate the discussion of these issues at this Symposium and in the future.

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Arizona Health Care Cost Containment System

Joseph P. Anderson

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program, has existed for a little more than four years. The program has undergone several major changes and has emerged a strong, regulatory state health care agency. Four major lessons may be learned from this demonstration program. First, adequate time must be allowed to plan and develop organizational structures and administrative processes. Second, personnel skilled in prepaid health care must be employed. Third, appropriate credentialing of health care plans is necessary to assure adequate capitalization or financial backing, an appropriate actuarial and rate setting process, proper financial reporting, and vigorous utilization control and prior authorization programs. And fourth, the program administration must act as a regulator with appropriate fraud and abuse detection systems, comprehensive financial and contractual compliance audit protocols, proper encounter data reporting systems, and active medical quality assurance programs. A review of the first four years of AHCCCS reveals a program that countered early problems to become a model for prepaid, indigent health care.

Creation of system • Six years ago, a county government fiscal crisis, due primarily to escalating indigent medical costs, inspired the Arizona legislature to create an indigent health care program based on managed care and prepayment principles. The Arizona Health Care Cost Containment System in November 1981 became the nation's only statewide prepaid Medicaid program.

Until then, Arizona was the only state not participating in the federal Medicaid program. Health care for Arizona's low income population was provided by the counties through county hospitals and clinics or contracted providers. Those services, however, were driving the counties to financial distress. In 1980 the counties estimated they were spending $122.6 million on indigent health care, an increase of 109% over the $58.6 million spent in 1975. Responding to the pleas for help, the legislature met in special session in November 1981 and created the AHCCCS program, which would begin operation 11 months later.

The Health Care Financing Administration approved AHCCCS as a three-year demonstration project in the spring of 1982. It began operation on October 1. Coverage includes the traditional Medicaid populations — AFDC or Aid to Families with Dependent Children, and SSI, Supplemental Security Income recipients — as well as a large state-funded eligible population referred to as the Medically Indigent/Medically Needy group. Enrollment in a prepaid health plan is mandatory for all members except native Americans, who may choose the Indian Health Service as a provider of medical care.

At present, AHCCCS serves 200,469 members. They include 127,983 AFDC and SSI members, 51,770 MI/MN members, and 20,716 children under a new eligibility program.

Health care is provided through health plans selected by competitive bidding and reimbursed primarily on a prepaid, capitated basis. The program covers most inpatient and outpatient medical services. There are waivers to exclude home health services, family planning services, mental health services, and

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the room and board component for long-term care, for which the counties are responsible. AHCCCS does cover medical services in long-term care settings. Since the waivers expire September 30, 1987, the legislature is addressing them as a package.

The original program design called for a private contractor to serve as day-to-day administrator whose responsibilitites included enrollment functions, health plan oversight, audit and compliance, claims processing, medical quality assurance, and grievance and appeals.

The program was implemented with very little time for planning and development. During the first 18 months it was beset with administrative and budgetary problems, culminating in the unscheduled termination of the private administrator's contract less than halfway through the contract term. The state assumed administration of the program. Governor Bruce Babbitt appointed a task force to manage the transition.

Reorganization • Within 30 days, the state successfully transferred the private administrator's system software to state computers, brought on-line a computer center with state-of-the-art hardware, and hired 150 employees. Governor Babbitt then appointed Donald F. Schaller, M.D., an experienced prepaid health care administrator, as the first director of this new state department.

Reorganization put AHCCCS in a strong, regulatory position to carry out duties such as:

1. Performing financial and contractual compliance reviews of the 19 health plans.
2. Quality control review of the MN/MI eligibility systems in the two largest counties.
3. Comprehensive medical quality-of-care audits of the health plans.
4. Increased staffing for the audits and compliance functions and for the medical director's office.

In addition, the county eligibility systems for the Medically Needy/Medically Indigent were revised to assure that only the truly eligible were covered.

This new regulatory stance was in sharp contrast to the laissez-faire approach of the prior administrative structure. Since the reorganization, two health plan contracts have been terminated due to plan insolvency and mismanagement, another plan has been reorganized with new HMO management under the federal bankruptcy statutes, and two financially troubled plans have sold their AHCCCS contracts to other plans.

Quality-of-care audits,[1] performed by out-of-state physicians who examine AHCCCS patient records maintained by primary care physicians, indicate that care is within generally accepted medical practice criteria. The audits, which are the most thorough review of any Medicaid program in the country, also indicate that AHCCCS members are being mainstreamed into the general health care delivery system.

An independent survey of AHCCCS members was conducted by the Lou Harris Organization, funded by the Robert Wood Johnson Foundation and the Flinn Foundation.[2] The survey found that AHCCCS members were highly satisfied with health care and access to health care had improved greatly.

The program was stabilized and the legislature and federal government extended the three-year project to five years. It will expire September 30, 1987, but negotiations are continuing with the federal government and the Arizona legislature for a further extension.

Participation • Seventy-one percent of Arizona's 6,240 licensed physicians (M.D.s and D.O.s) participate in AHCCCS either through its fee-for-service or prepaid component. Forty-seven percent of all licensed physicians are affiliated with prepaid health care plans in the AHCCCS network.

Stanford Research Institute is under contract with the federal Health Care Financing Administration to evaluate AHCCCS. Its latest evaluations compare AHCCCS costs with a traditional fee-for-service program and show that AHCCCS costs in fiscal 1983 ranged from a negative $85,000 to a savings of $3.2 million.[3] In other words, the potential for savings was greater than the potential for loss.

AHCCCS is funded by the state, its counties and the federal government. The current budget is $293,667,173. At present, AHCCCS contracts with 14 health care plans and bids are accepted on a per-county basis. Five of the 14 plans, however, serve more than one county.

All of the current private AHCCCS plans were formed to bid on AHCCCS contracts. In addition, Maricopa, Pima and Pinal Counties, plus the University of Arizona Medical Center, reorganized themselves into prepaid health plans and also bid on contracts.

For the past four years, AHCCCS has issued one-year contracts with one-year renewal options. Three HMOs now operating exclusively in the private sector have indicated an interest in bidding on 1987-88 contracts. RFPs not only require the plans to bid by county, but by rate code of eligibility.

During the last year, the AHCCCS program has been expanded to include more children, to make it easier for pregnant women to obtain prenatal care, and to develop a program which offers small employee groups affordable health care coverage.

The expansion to include more children will add approximately 25,000 members during 1987. Governor Babbitt supported this expansion based on increasing evidence that children are going without necessary preventive services.

In his State-of-the-State address in January 1986, Babbitt said that "more than one fifth of all children

in this country, and about the same proportion here (meaning Arizona), live in poverty today . . . We cannot minimize the bad by merely wishing it otherwise."

In Arizona, about one half the children in families with incomes below the federal poverty standards are ineligible for AHCCCS. Most of these families cannot afford health insurance. Their children receive no health care unless their illnesses reach serious stages. When they do seek care, it is often in a hospital emergency room where treatment is expensive.

The governor asked the legislature to expand AHCCCS eligibility to include children ages 14 and under from families with incomes below federal poverty levels. The legislature, however, expanded the program only to include those children ages five and under because of tight budget constraints.

The children's program recommended by the governor fulfilled a need later recognized by Congress. In the Omnibus Reconciliation Act of 1986, Congress authorized the states to offer optional Medicaid coverage to infants up to age one, and — at yearly intervals per age group thereafter — to children up to age five from families with incomes up to the federal poverty level.

In Arizona, children age five and under seeking eligibility will now receive health care as early as possible. The program includes two avenues to eligibility. First, any child age five and under whose household currently is receiving food stamps automatically will be eligible to receive AHCCCS services. Second, for children whose households do not receive food stamps but whose incomes fall below the federal poverty level, eligibility will be determined by the counties in the same way as the current eligibility process.

The most important feature of this program is that it extends EPSDT (Early Periodic Screening, Diagnosis and Treatment) services to these children. This includes all necessary checkups, immunizations, dental care and medical inpatient or outpatient treatment.

AHCCCS evaluated each health plan's provider network to ensure it could serve these children before awarding the plan a contract amendment.

AHCCCS also has implemented a maternal and child health program which makes it easier for pregnant women to become eligible — and remain eligible — for health care through the births of their babies.

To ensure early prenatal care, AHCCCS has instructed the counties to process on a priority basis all Medically Needy/Medically Indigent eligibility applications filed by pregnant women. This cuts the waiting time from up to six weeks to a matter of days, and allows pregnant women eligible for AHCCCS to extend their eligibility from the regular six months to one month after the month of delivery.

Since the program focuses on delivery of healthy babies, any child born under this program will be covered under the mother's health plan as long as the mother remains eligible.

Working uninsured • Another improvement in AHCCCS involves the uninsured. Since AHCCCS is the safety net for uninsured health care — a person can qualify for the program by subtracting annual medical expenses from annual income to reach the qualifying income level — the program is experiencing an increasing problem with the "notch group," which AHCCCS defines to include anyone, regardless of income, who does not have health insurance. A number of factors have contributed to the growth of the notch group.

First, a coalition of businesses in the Phoenix area attempted to shift some of the health care dollar decision making process onto employees by raising premiums, copayments and deductibles. In some instances, this seemingly pushed low-paid employees and/or dependents out of insurance coverage.

Second, large employers changed their employee composition either by hiring more part-time workers ineligible for health care coverage or contracting out work to medium and small companies which do not offer health care coverage.

Third, small businesses have proliferated, and there is a multitude of reasons why many do not offer insurance coverage. Some employees, primarily the young, feel they are "immortal" and do not need it. Also, some insurers exclude from group rates employers with ten or fewer employees. And, while some companies offer coverage at low rates, many small employers are unaware of them, or the deductibles and copayments are so high in relation to the employees' incomes that they are unattractive to potential purchasers.

The working uninsured represent a major, growing problem across the nation, and the lack of insurance presents a problem not just to the people going without coverage, but to health care providers and taxpayers.

According to studies conducted by two health systems agencies in Arizona, there are about 62,400 people in just eight of the state's 15 counties who are employed but have incomes below federal poverty levels and do not have health insurance. Our studies indicate there are 251,371 people in Arizona who work for companies with less than 19 employees. Of those companies, 43% do not offer health care insurance. That means there are potentially 108,090 employees going bare and, when dependents are added, the number could be as high as 238,000.

When uninsured people become ill, the burden falls on the medical community and taxpayers. In 1984, Arizona hospitals provided $138.5 million in uncompensated care, according to reports filed with the state Department of Health Services.

A majority of Arizona's uncompensated care in

1984 was provided by county hospitals, that is, directly subsidized by the taxpayers. Uncompensated care provided by noncounty hospitals is subsidized in other ways, primarily through higher rates passed on to insured and self-pay patients. These hospitals may launch collection proceedings, but, in the end, much of that care will be written off as bad debt or charity.

There have been a number of proposals made over the past few years in Arizona to cope with the uninsured population. None has been implemented. The proposals have included the passing of laws which would require all employers to offer health insurance; raising AHCCCS eligibility limits to include more low-income people; imposing new taxes on alcohol and tobacco products; imposing premium taxes on health insurance policies, and creating special tax incentives for small employer groups which do offer health insurance and tax penalties for employer groups which do not.

Each one of those proposals would require governmental intervention and many of them would be direct subsidies, as in the case of raising AHCCCS eligibility criteria, or new taxes or tax incentives or penalties.

The impact of the uninsured already is being felt by AHCCCS. Some people qualify for the program who are not "indigent" in the classic sense of the word. They earn $20,000, or $30,000, even $60,000 a year, but become eligible for indigent health care because they "spent down" their incomes to poverty levels. Also, from fiscal 1984-85 to 1985-86, the AHCCCS program experienced a 20% increase in the number of people hospitalized on the day they were determined eligible for indigent health care. That meant they were coming into the program at a very expensive point.

There are multiple solutions to the uninsured problem. One of them, obviously, is through traditional expansions of Medicaid, meaning larger expenditures of tax dollars. In Arizona, however, the magnitude of the problem, conservative nature of the legislature, and lack of available state funds make such a solution impractical.

Instead, the AHCCCS program is developing a small-business service product. AHCCCS has received a $346,000 grant from the Robert Wood Johnson Foundation to implement the Health Care Group of Arizona, or HCG.[4] The goals of HCG are to reduce uncompensated care, head off potential liabilities for taxpayers and increase the overall health of the population.

Under HCG, AHCCCS health care plans will be able to market coverage to small employee groups. That program is scheduled to begin October 1, 1987.

HCG will provide prepaid health care coverage to groups of 25 or fewer employees. Coverage will be marketed through commissioned agents and brokers and through contracting AHCCCS health care plans. Thus, HCG marketing and coverage will be provided to the private sector by the private sector.

AHCCCS intends this coverage to be marketed to those employers who do not offer insurance, rather than those who do. The HCG is aimed at bringing health care benefits to those businesses.

HCG will be self-sustaining through premium payments. Care will be provided through the health plans serving AHCCCS members. Pilot programs are being planned for two or three counties this spring.

Existing state law sets specific parameters for AHCCCS plans to market to private employer groups. Under that law, AHCCCS will design the HCG benefit package, ask existing AHCCCS plans to submit bids on covering the small employer groups, and collect and disperse premiums.

Since AHCCCS announced the receipt of the Robert Wood Johnson Foundation grant in August, at least two health insurers have amended their advertising to announce special programs for small businesses. Some mainline HMOs have requested information so they might bid for AHCCCS members in the spring of 1987. This new interest in the small-case market is encouraging.

AHCCCS surveys indicate that the first-year goal of enrolling 20,000 in the HCG program is realistic. And, that means 20,000 people who will not be exposed to the dangers of doing without health care coverage.

Conclusion • AHCCCS has gone through several major changes in the first four years of its existence. As a result, the program has been strengthened and improved to provide the best possible health care to those who become eligible. The problems that surfaced in the early years serve as a reminder to those entities attempting similar programs to plan adequately, employ personnel skilled in prepaid health care, provide appropriate credentialing of the health care plans, and operate as a strong regulator.

Only with a well-balanced regulatory approach will the public be assured of proper expenditures of tax dollars. The providers will be assured of a fair competitive system, and the members will be assured of quality medical care.

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Survey of Florida's 67 counties

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The Florida House Committee on Health and Rehabilitative Services sponsored a Star Grant in 1984 for the purpose of examining in more depth the indigent health care issue. The grant was awarded to the Center for Health Policy Research and the Center for Governmental Responsibility at the University of Florida. The research supported by the grant had three major objectives: (1) to examine the legal role of counties and special districts in delivering and financing indigent health care services; (2) to determine the extent to which these services are being delivered by counties and hospitals; and (3) to develop a uniform definition of medical indigency that can be used as a guideline for distributing funds from the Public Medical Assistance Trust Fund (PMATF) back to hospitals.

Several research methods were employed. A review was conducted of the law and legal literature as well as the general literature. Hospitals and county governments were surveyed to learn the sources, amounts, and distribution of funds for indigent care, and large indigent care providers were visited. Finally, a Technical Advisory Panel drawn from government, industry, and indigent advocacy groups advised the research team on formulating indigency guidelines and definitions.

The Florida Constitution does not define the role of local governments in delivering indigent health care; therefore, this role is defined in the Florida Statutes. The Health Care Responsibility Act (HCRA) assigns the ultimate financial responsibility for indigent care to the patient's county of residence, but ambiguities in the statute make the extent of this responsibility unclear. Counties are required to participate in the funding of the Medicaid program and may share this responsibility with special districts. Counties are also authorized, but not required, to provide health programs to their residents and to contribute to a trust fund for public health units.

Survey findings • Sixty two of the 67 counties responded to our survey. Forty five counties funded indigent health care programs which were not mandated by the state while 17 counties did not. The county-funded programs amounted to approximately $176.8 million, with a range extending from $20 to $95.6 million. Fourteen counties spent over $1 million each while 15 counties spent less than $100,000. Per capita expenditures ranged from $.01 to $55.01, with 13 counties spending more than $10 per capita.

In addition, 32 counties paid slightly more than $1 million to other counties under the Health Care Responsibility Act. All counties contributed $39.5 million to the Medicaid program and five counties made $6.8 million in direct hospital appropriations. Finally, hospital tax districts spent a reported $45.1 million for indigent health care programs within hospitals.

Hospital care, the most frequently funded type of service, was financed by 37 counties. The largest expenditure was for inpatient care and the lowest expenditure for hospital psychiatric care. Clinic services were funded by 36 counties. The largest expenditure was for general clinic services while the lowest was for family planning and dental clinics. Many of these latter services, however, are provided

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by public health units. The most frequently funded "other" type of service for indigents was prescription drugs.

Members of the research team made site visits to Broward, Dade, Duval, Escambia, Hillsborough, Orange, Palm Beach, Pinellas, Polk, and Volusia Counties. County officials expressed many different concerns. The most frequent was lack of physician participation in the Medicaid program. They also called for clarification and enforcement of the HCRA. Various counties mentioned special concerns and pressures including maternity care, transients, refugees, the working poor, and Baker Act patients.

The legal review also determined that hospital special districts have no requirement to provide indigent care. The individual special district charters are the sources of information about indigent health care obligations. Some charters require or permit funding of indigent or charity care, while others are silent on the matter. We were able to obtain information on 19 hospital special tax districts, although many more are operational. These 19 districts reported 1983 revenues of over $430 million. Fourteen districts reported expenditures for indigent care. One spent none of its $2.6 million for charity care services, while the remaining 13 districts spent just over $45 million.

Our research led us to conclude that there is significant noncompliance with charter requirements and noncompliance with legally mandated reporting requirements by hospital special districts. One charter called for 100% expenditure of revenue for charity care services, yet the report indicated about half of the revenue was spent for such care. Special districts have complex reporting requirements to both county and state entities, but serious violations of these requirements were noted.

Recommendations • Several policy recommendations were generated by this study. Mandatory county funding of indigent health care should be considered, perhaps with some minimum level requirement being phased in over time. To avoid potential county bankruptcy due to the occurrence of one or two very severe illness episodes, a state-subsidized catastrophic illness insurance program for the poor should be implemented. The Health Care Responsibility Act should be clarified and enforced, with more generous income guidelines and centralized administration. The funding levels of the Medicaid program (especially physician fees) and the regional referral programs should be improved. Sources of funds for community-based mental health services as well as refugee care need to be explored. Strong priority needs to be given to establishing a state medically indigent funding program to assist hospitals that carry the indigent care burden. This involves developing a mechanism for distributing funds from the PMATF back to the hospitals that carry a disproportionate share of the indigent care burden, and exploring more broad-based sources of tax support. And, finally, the state should consider mandatory special district funding of indigent health care once the accountability of tax districts is improved.

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The indigent care problem

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The indigent care problem is one of great magnitude and complexity. It exists throughout the diverse components of our health services delivery system. It is, however, most visible in the area of inpatient hospital services.

Until recently, the problem was frequently the subject of rhetoric but far less often the focus of rigorous empirical analysis. In part, that lack of analysis reflected the difficulty of the research issues. In addition, however, it derives from a notable lack of the kind of patient specific data necessary for detailed and comprehensive analysis.

Indigent care study • In 1984 the Florida legislature recognized this difficulty. As part of the Health Care Consumer Protection and Awareness Act, a comprehensive study of this issue was mandated. The study was conducted by the Center for Health Policy Research at the University of Florida under contract with the Hospital Cost Containment Board.

The methodology of the study has been described elsewhere.[1] However, a brief summary of certain features of the data collection technique and the resulting data base seems appropriate at this time.

The study utilized three instruments. A patient selection form was used to determine whether or not a patient should be included in the study. The form assisted hospital personnel in selecting patients who seemed likely contributors to the problem — e.g. those without insurance, the unemployed, and those with particularly high cost conditions. When a patient was selected for inclusion, his financial record was flagged and further data were obtained. In this second stage — still at or near the time of admission — a patient data form was used to gather demographic, income, family composition and similar information about the patient and (if applicable) the guarantor. In a third stage of data collection, detailed billing information was obtained, typically by asking hospitals to forward a copy of the patient's UB82. Finally, approximately 150 days subsequent to the initial data collection, the hospitals were asked to complete a financial data form and provide detailed information regarding the amounts collected, by source of payment, any amounts unresolved, and the hospital's intentions regarding those residual amounts, if any. The amounts unresolved and the patients who generated them are the core element in our study's approach to examining the indigent/uncompensated care problem.

The data base contains about 14,000 cases. Each case represents an individual who experienced an inpatient hospital episode in Florida during the period April through June 1985. One hundred sixty three (71.8%) of Florida's 227 eligible hospitals participated in the study. One hundred thirty of those gathered data effectively. In total, over 68,000 patients were screened with approximately 28,000 being flagged for inclusion in the study. Of the latter, 14,563 cases have passed a series of edit checks and contain valid data on certain key variables. This large and unusually detailed data base provides an opportunity to explore a myriad of issues within the larger indigent care problem. The following comments are intended to emphasize only four fundamental points.

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Indigent care issues • First, the data base confirms the enormity of the problem, and especially the inpatient component thereof. While the screening methodology prohibits derivation of precise estimates, our study lends support to other sources which place this portion of Florida's problem in the area of $450-$500 million per year.

Second, our data confirm that unresolved hospital charges are primarily generated by patients who have no third party coverage of any kind — public or private, group or individual. Seventy-two cents out of every unresolved dollar in our data base are generated by patients under 65 years of age who are completely without coverage. While other patients certainly contribute to the problem, its central component appears to be a lack of insurance.

Third, these uncovered patients do not conform to popular stereotypes of the poor. They are not, contrary to some public opinion, primarily street people, or unwed mothers, or members of racial minorities, or any other easily defined group. Although the uncovered group is younger, and slightly less likely to be married, its distributions on such variables as sex, race, income, employment status and the like are remarkably comparable to those of patients with some form of coverage.

Finally, the hospital bills generated by these patients (the uncovered/under 65s) appear to fall into three identifiable groups. A large number (31%) of bills are relatively small ($1,000 or less). Almost 35% of these bills are paid in full. Among those not paid in full, the amounts outstanding are such that they sum to only 5.88% of the total amount unresolved. A very small number of bills occupy the opposite extreme. Less than 1% of our cases have bills in excess of $25,000, and 80% of these cases contribute to the total amount unresolved. Interestingly, these few cases account for over 15% of that total amount unresolved. Finally, we note that over two thirds of the patients under discussion here have bills which fall in the middle range — between $1,000 and $25,000 with most of these in the $1,000 to $3,000 range. Few of these bills are paid in full, and they contribute almost 80% of the total amount unresolved.

Public policy development • These findings have a number of implications for the development of sound public policy to respond to the indigent care problem. First, it is clear that the problem is not located in some easily identifiable group of patients. Thus programs which are targeted to such subgroups will leave major population segments unimpacted. Second, although it would appear that hospitals could be more effective in their collection activities, especially in cases where the bill is modest, such action would not represent a major solution. Clearly, we must design a mechanism which provides coverage for patients who are currently generating these unresolved amounts, and for the hospitals which are currently absorbing those costs.

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Care for the medically indigent: a major challenge for Florida

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Providing health care of acceptable quality to the medically indigent population of the United States continues to be one of the most difficult problems facing this nation. The National Medical Care Expenditures Survey conducted in 1977 showed that 12.6% of all Americans were not insured by either private coverage or public programs such as Medicare or Medicaid. Another survey in 1980 showed 13% were uninsured. Bureau of Labor statistics show an increase of uninsured Americans under 65 from 14.4% in 1979 to 16.5% in 1982. Estimates now demonstrate that at least 30 million Americans are uninsured for all or substantial time periods each year.

The indigent populations throughout the United States, including Florida, are served by different systems of care from those available to people receiving private care. Whether in urban or rural areas, there are limitations on the kinds of care available to the poor, and the quality is subject to considerable variability. Common characteristics are the limited resources and options available for choice. Another feature is the lack of continuity of care.

Health care for the poor is usually episodic, with some being provided in city or county hospitals, some in other hospitals, some in health departments or community health centers, and some in offices of private physicians. There is seldom a single provider or family physician to coordinate care — "a medical home." Generally, different physicians or other providers are seen with each separate health need or episode of illness.

In Florida, as in other parts of the nation, immunizations, family planning, maternal and well baby care may be obtained from the local health departments, primary care may be obtained from a community health center, where available, a considerable amount of care is provided by private physicians in offices or community clinics, and for emergencies or inpatient care, the local (or nearest) hospital is the usual provider. Government owned facilities are used where these are available. Cultural and language barriers are very real problems, and sources of care are seldom adapted to overcome them.

Florida shares with other parts of the United States great variability in methods of payment for health care of the poor. Medicaid or "Title 19" funds were originally intended to move the poor into a better system of care. However, there is great variability in Medicaid programs among the states, the eligibility criteria are restrictive, payments to providers are low, and the amount of paperwork is excessive so physicians and health facilities have often been reluctant to accept Medicaid patients. Florida funding of the Medicaid Program continues at a very low level. Counties do not have adequately funded social service programs and their eligibility criteria can also be quite restrictive. Local support of indigent health care varies considerably throughout the state and in some counties it is extremely small.

One result of the uncoordinated, crisis oriented care available to indigent patients, both nationally and in Florida, is a lack of emphasis on preventive services. Problems which could have been prevented entirely,

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or minimized through early detection, are allowed to become critical before help is sought. The result is often conditions which require prolonged, expensive treatment and rehabilitation. The patient may not recover, with resulting loss of the breadwinner or homemaker, and the impact of such loss on the family and community.

Florida obviously shares problems of other states in regard to health care of the poor, and we have certain characteristics which make these problems more critical. For one thing, the state's climate and other factors attract people from other states and foreign countries who are medically indigent. Florida's growth management challenges certainly include the indigent health care issue. In our state there is great disparity of resources for provision of health care. Increasing cost of medical care has created serious fiscal, administrative and related problems for hospitals, physicians, public health agencies and other providers. Malpractice suits and the cost of liability protection have compounded the problem of providing medical care and are responsible to a considerable extent for the increasing cost.

In addition to fiscal aspects, indigent care poses a number of other problems. Cultural and language differences are obstacles to be overcome in obtaining effective cooperation. Lack of transportation, especially in rural areas, interferes with clinic attendance. Educational limitations are factors to be overcome. Areas of greatest need are often those where resources are most deficient.

What can be done about these problems? Obviously, there is no single quick solution. In Florida, local communities are developing a number of innovative approaches utilizing available resources. Since problems as well as resources vary considerably, home grown solutions are usually better than those contrived in Washington, or even Tallahassee. If there is any single factor that is essential for success, it must be cooperation: between private and public sectors, state and local agencies, various organizations and individuals.

One approach toward dealing with these complex problems has been developed in Palm Beach County. With its diverse population, urban and rural areas, and rapid growth, Palm Beach County has examples of problems which can be found in other parts of the state.

About 30 years ago, the burden of indigent medical care was falling heavily on the four voluntary or tax district hospitals (there is no public hospital dedicated to indigent care in Palm Beach County). One of the hospitals was in severe financial straits due to carrying a disproportionately large part of this load. Hospitals and physicians' offices were overloaded with emergencies.

The Board of County Commissioners asked the County Health Department for assistance in solving these problems. A first step was to meet with representatives of the medical society and hospitals to develop a cooperataive plan. The plan involved addition of responsibility for primary care to the other Health Department services, with additional staffing of clinics by private physicians who also would take referrals for specialty care, and agreements with hospitals for inpatient and emergency care.

Fortunately the Health Department had the benefit of a rather extensive program of health care for agricultural migrants which had been initiated in the mid 1950s. This project, which was partly financed by Children's Bureau funds, had shown that medical care of acceptable quality could effectively be added to the traditional public health services.

Prior to the initiation of the migrant health program, a special study had been conducted to learn more about the kinds of pathology affecting migratory agricultural workers and what acutally occurred in regard to their health problems as they moved from one state to the next in the Atlantic Coast stream. The study documented a broad spectrum of disease and demonstrated the inadequacy of care received by the workers, not only in the home base area, but also as they migrated, following the crops.

Based on these studies, a plan for providing care was developed which involved a team approach. The team included physicians, family practitioner and pediatrician, public health nurses, nutritionist, medical social worker, health educator, sanitarian, and a liaison worker recruited from the migrant population who could describe the problems from the viewpoint of the migrants and interpret health information in language they could understand. The team was able to combine expertise in evaluating health problems and implementing treatment plans. More than medical knowledge was required and the public health nurses, social worker, nutritionist, health educator, sanitarian and liaison worker all had key roles in this effort. The lessons taught by this experience were of great benefit in further development of health care programs for the general indigent population.

A basic ingredient of any successful program in health care is personnel of the highest quality. Governmental personnel policies cannot be relied upon to attract and retain the best quality of health professionals, except for those individuals who are specially motivated toward a career in public health practice. One of the best ways to attract such individuals is through accredited training programs.

Recognizing these facts, in 1956 the Palm Beach County Health Department applied to the national accrediting body for approval of a residency training program in preventive medicine. After a rather lengthy process of critical review, this program was approved. Immediately, it began to attract exceptionally well qualified young physicians. While with the Palm Beach County Health Department, these physicians have provided a necessary ingredient for health

services of high quality. Their expertise is especially important when the health services include general medical care.

Similar training programs were established in dentistry, nursing, environmental sciences, and other disciplines. They were developed in cooperation with various universities such as the University of Miami, University of North Carolina, Florida Atlantic University, and the University of Florida. These training programs have been a source of recruitment and retention of high caliber personnel. They deserve a major share of credit for the development of health services in Palm Beach County. Such educational programs can and should be essential service building elements in achieving health care of acceptable quality.

Since their initiation, the medical care programs have been progressively integrated into the traditional public health services such as communicable disease control, health education, basic maternal and child health service, environmental health and others which emphasize the prevention and control of disease. These services are delivered by staff who are located in six different geographic areas of the county. This decentralization has significantly reduced the transportation problems previously experienced.

Physician staff includes specialists in internal medicine, pediatrics, family practice, obstetrics and preventive medicine. Almost all physicians are board certified or eligible. They are able to take care of most of the problems which come to their attention. Referrals are made to other specialists in the private sector. Staff physicians also take care of a substantial number of indigent patients in hospitals and coordinate their services with other members of hospital staffs. Public health nurses visit hospitals on a regular basis, coordinating patient care and promoting continuity. Agreements with the hospitals for inpatient and emergency care are renewed annually. The health centers provide clinical laboratory and radiology services which are augmented by commercial, hospital and state laboratory services as required.

Pediatric and other staff rotate on call after hours and on weekends. This has been especially helpful in providing maternity and pediatric care for high risk mothers and infants.

In Palm Beach County the provision of medical care has not detracted from the preventive services; on the contrary, it has enhanced them. The medical care program brings individuals and families into the health centers where they can also receive preventive services. This includes individuals whose cultural patterns do not recognize the importance of disease prevention or health promotion. Likewise, the quality of medical care is enhanced by the emphasis on preventive services such as health education, health risk assessment, nutrition counselling, and immunizations.

From an administrative standpoint, there are distinct advantages in having immunization, control of sexually transmitted diseases and tuberculosis and other public health services immediately available along with a variety of medical care services, because it facilitates coordination of all these services. Even environmental health services can be included because these are often needed to control diseases which have their origin in pollution or poor sanitation. From the standpoint of the clients or patients, it is helpful to have a single source of care. This minimizes the need to go to several different places to receive various services which could be provided in a single location.

In regard to the concern for escalating cost of health care, this kind of program may have substantial advantages. Every effort is made to keep patients out of the hospital for conditions which do not require this expensive resource. The programs emphasize prevention of illness through immunization, risk factor identification and reversal, health promotion, sanitation, and health education or finding and treating disease early before it becomes a major and costly problem. When hospitalization is required, length of stay is kept to a minimum through early discharge policies and use of modalities such as home care, extended care and other less expensive resources.

A program such as this could not be possible without close cooperation with the medical community, hospitals and other providers of care. Frequent planning sessions are held with them, and relationships are formalized, where indicated, with contracts and agreements. Included in this process are hospital administrators, medical staffs, hospital emergency room staffs, home care agencies, nursing home representatives, laboratories, and private physicians for specialty care.

What have we learned from this experience which may be helpful to others?

1. There are a number of ways in which Florida communities can improve health care for the medically indigent population. Each community may well have its own unique "answer."
2. Any local plan for community health services should be developed by providers and community representatives who will be involved in implementation of the plan.
3. Cooperation is the key element in the success of any plan.
4. Integration of medical care with public health services can be successful in providing health care of acceptable quality to the medically indigent population in a cost effective manner.

In summary, Florida must come to grips with its large indigent health care needs in the immediate future. Governor Martinez has highlighted indigent health care as the major human service issue. The Florida Medical Association as a professional activistic organization has likewise focused on this issue. We all need to work together to develop flexible, locally designed, primary and secondary indigent care

systems. Full involvement of the private sector is essential. If we fail to accomplish this, the basic health of our medically indigent population will continue to deteriorate, in an increasingly competitive and fragmented medical marketplace. Leadership of the Florida Legislature and the Governor will be required in completing the spirit and thrust of the Health Care Access Act of 1984 toward addressing our indigent health care needs.

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Indigent care in Orange County

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Indigent care as related to county health departments has been provided in some fashion since the 1930s beginning with maternal and child health services by public health nurses and evolving to comprehensive health care programs in 1986. Today, primary health care programs vary from county to county as do eligibility requirements. Not all indigents receive primary health care services and very few of the medically indigent/working poor have access to care. Certified indigent patients eligible for Orange County services have an average income of $10,000/year or less for a family of four. This population is in the neighborhood of 40,000 people not including state eligible Medicaid patients estimated to be 20,000. The three groups unable to afford or access private medical care — county indigents, working poor/medically indigent, and Medicaid patients — have been the focus of much attention in Orange County and in the state this past year. Arguments as to who is responsible for their care continue to flourish but, as yet, there have been no clear-cut answers regarding overall fiscal responsibility, particularly for the medically indigent and working poor.

Medical care network • In Orange County a network of medical care for the certified indigent population had been in place since the 1950s. It mainly utilized three health providers, county health department, county indigent care clinic, and Orlando Regional Medical Center (ORMC). The county health department served as a focus for preventive and general health services primarily targeted at mothers, infants and children. The county-funded indigent care clinics extended the network by providing primary care to the adult indigent population. ORMC and its teaching programs, along with attending staff, fleshed out the network by providing secondary and tertiary care including hospitalization if necessary. This combination of services funded by local and state funds enabled the county's indigents, and many of the Medicaid patients, to have a source of medical care which was an example of outstanding cooperation in a county with no medical schools nor public hospitals. While the Florida Hospital in Orlando, and its family practice residency program, the CMS program, the West Orange Farmworkers' clinics (federal program), and many individual private physicians carried part of the indigent/medically indigent load, the preponderance of primary, secondary and tertiary care was provided in the network.

This effective system endured for over 30 years until medical economics became a reality that could no longer be ignored with changes occurring in the way hospitals were reimbursed starting in the 1980s. Unfortunately, ORMC, a private, nonprofit teaching hospital, began to feel the financial crunch of taking care of indigent patients for many reasons, but mainly it no longer was able to shift the cost to paying patients or insurance companies providing health protection, along with changes in the federal Medicare program.

In 1986 when ORMC's share of uncompensated care continued to rise, the Board of Directors called for a reveiw of its role as a predominant provider of indigent care in the county. It was decided that a "fair share policy" must be instituted with other hospitals

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strongly encouraged to become part of the network with the Orange County Health Department and the county indigent care clinic.

The Orange County Health Department and county indigent medical clinic immediately felt the effect of this policy. They had to look to other hospitals for care of obstetrical patients, and medical/surgical patients not in ORMC's defined service area. ORMC would be reducing its indigent caseload by 50%. Administrators at the other six hospitals in Orange County said they did not want the indigent patients formerly cared for by ORMC. Various quotes from the Orlando newspaper by other hospital administrators were: "We just don't have a magic money tree." "If we take all of ORMC's obstetrical patients in our ZIP code, we would have very severe financial problems in operating." "I have taken a long look at indigent care, and have come to one conclusion — a solution needs to be found soon."

Other health providers around the state have commented that "indigent care is easily one of the biggest problems facing the medical industry and, if you want to level the playing field and let hospitals compete, someone has to pay for taking care of poor people."

Where do we go? • Where do we go from here in Orange County where a long-time service to the poor in a previously excellent network of cooperation has suddenly come to an end? The answer does not come easy since we must find a way to redistribute indigent patients to other health providers in "service areas" and a reasonable source of funds to provide for a new network of care. Hospitals and private health providers who previously reduced charges for their services now want a change in this practice, and rightly so. In order to enlist the support of private obstetricians in delivering indigent patients who received prenatal care in the health department, it has been necessary to employ at least ten physicians temporary and part-time so they could be covered under the state's sovereign immunity umbrella. The malpractice situation is so critical in the area of obstetrics that few, if any, of these physicians will deliver our patients without the added protection. Sovereign immunity coverage for physicians providing free or low cost care to indigent patients is essential to establishing a network of care to the poor in Orange County and the State of Florida.

The state legislature will be addressing the indigent care problem during the 1987 session. One prefiled bill, the Reddick/Woodruff bill, would levy a broad-based tax to help cover the cost of indigent care. It would provide funding and establishment of primary care networks in each county similar to what we had in Orange County, with the health department's clinics acting as primary care providers for the indigent and a working relationship with private physicians and hospitals to extend the spectrum of care. This bill would cover poor people with incomes up to 150% of the poverty level. Those over 100% of poverty would be charged fees on a sliding scale to help cover the cost of care.

The Florida Medical Association is interested in the concept of a broad-based tax to care for the indigents, along with other programs including sovereign immunity, and state insurance coverage of those who cannot access or afford health insurance. These proposals will make for an interesting year and, hopefully, some solution to our problems will be forthcoming.

The Orange County Health Department and the county indigent care clinic have worked with private physicians and hospitals for many years, and look forward to a continuation of this relationship. We need to work together to establish a system of care that includes both the private and public sectors. With additional help from the legislature, we can provide a high level of health care to all citizens of Orange County that will be acceptable to them and to health care providers. Their interest and cooperation are essential to keep health care, private or indigent, in the mainstream of private medicine, rather than have a public system established in the State of Florida. We accept the challenge to provide public health services to the degree necessary in Orange County and ask that the hospitals and doctors do the same so that anyone in need has access to medical care.

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Primary care programs for the indigent

James K. Conn, M.D., F.A.C.S.

Two issues represent the biggest problems facing the medical profession today: provision or lack of health care for the indigent and care, medical and social, of the elderly. These, of course, are really problems of society since, at the core, financing is involved but they are of concern to our profession and the allied professions as well as government agencies.

Health Care Access Act • Florida was a bellwether among states when the legislature passed the Health Care Access Act in 1984. Through this act, concern was officially expressed for the accessibility and affordability of health care for all Floridians, but especially for those unable to provide for it themselves.

One approach, authorized by the Act, was to establish primary care programs for the indigent using county public health units (CPHUs) as the vehicle. Ten million dollars were appropriated to be awarded as grants to CPHUs for this purpose. Fortunately, or perhaps unfortunately, the method for establishing a program was not specified; also, the nature of a program was not defined. It is not clear whether this was because nobody wanted to undertake such a task or because it was assumed that everyone understood what primary care is.

At any rate, a task force was formed by the Department of Health and Rehabilitative Services (HRS) to describe what a primary care program should be and do. The result was a Request for Proposal (RFP) specifying certain requirements that had to be met in order for a grant request to be considered. A comprehensive program was described which included acute medical care, chronic disease follow-up, diagnostic capabilities, consultant availability, access to hospitalization, and more. In summary, a Primary Care Program was defined. Responding to this RFP, 33 counties submitted proposals and, limited by the available money, 17 proposals from 18 counties were accepted and received funding, based on need and the perceived performance capabilities.

The counties were given complete flexibility as to how they wished to organize the program as long as it met RFP requirements. They could keep it in-house, subcontract the entire program to an established clinical entity, or subcontract some elements and keep others in-house. This appears to be rather straightforward but it became clear that there was no consensus as to the definition of primary care. CPHUs rightfully consider that many of the services they have been providing for years are primary care services. How they fit into a comprehensive care program, however, has been a question that defies an easy answer. Also, primary care has been a term extensively bandied about, and assuming that everyone knows what it means, much misunderstanding has resulted, different people perceiving different meanings. The purpose of this presentation is to attempt to reconcile these divergent opinions as to what constitutes primary care and to define a primary care program.

Primary care • This topic is examined in depth by Smith and Churchill.[1] They summarize an extensive bibliography and state: "Enough has been published to advance the claim that there is increasingly a broad, tacit consensus about what primary care is and what

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it ought to do." Alpert and Charney[2] describe it in this way, "Primary care is not synonymous with comprehensive medicine, social medicine, personal medicine, or family medicine; these overlap with primary care but cannot be used interchangeably with primary care. Primary care is first contact medicine which assumes longitudinal responsibility for the patient regardless of the presence or absence of disease, and serves as the integrationist for the patient."

Janeway[3] puts it thus, "The fundamental base of primary care is health promotion, identification of individuals at special risk, early detection of serious disease, management of acute emergencies, and the ability to render continuing care to chronically ill patients." Millis[4] simplifies it as all health care needed by a given population not provided by secondary or tertiary care.

In light of the foregoing, and with many additional published opinions, it appears that there is a consensus, but a problem may still remain in defining the terms, accessible, comprehensive, coordinated, and continuity which are keys to successful primary care. Smith and Churchill believe that these definitions should not come from doctors alone nor solely from consumer advocates. They advance the idea: " . . . primary care is not descriptive merely of the context of medical care which embraces a normative purpose somewhat at variance with current customs and practices. In primary care the emphasis is on the patient as a psycho-social being as well as an instance of a disease entity, and it assumes a larger and consistent responsibility for patient care over time." Looked at in this way, primary care is seen more as a philosophy of practice, an attitude involved with quality, rather than as a type of practice that can be defined quantitatively.

Primary care is patient oriented and to be successful, in the light of current thinking, requires patient involvement and concern for the patient's values. Again referring to Smith and Churchill, medical care is right only if it is clinically valid and good only when it conforms to the patient's values. Implied is a great effort exerted toward understanding on the part of the physician, and equal effort exerted in the educational process of the patient. The patient, in turn, must be desirous of developing this relationship and must be able and willing to respond with a degree of independent initiative and cooperation.

It has been accepted that primary care properly belongs in the realm of certain specialties, namely, family practice, pediatrics, internal medicine, and obstetrics/gynecology. Certainly these specialties are best equipped to satisfy the characteristics that describe primary care. At the same time, general surgery and some of the surgical subspecialties claim that they, too, practice primary care, and this is true inasmuch as a surgical specialist may be the first contact resource when a nonsurgical problem arises in a satisfied former surgical patient. Carried further, we know that some cardiologists provide general medical services including referral and coordination for some patients and I am sure the same is true for other internal medicine subspecialties. Regrettably, the motivation for this is often an insufficient need for their limited subspecialty, but also it often must be due to the desire to maintain that mainstream relationship with patients.

Reduced to utmost simplicity, primary care is the provision of acute medical care for an individual and the coordination of all his/her health care needs. In addition the practitioner must actively participate in activities designed to keep the patient in an optimal state of health. It is the most difficult type of medical practice because it implies a total commitment, a sublimation of self, on the part of the physician. It implies a working partnership with the patient, jointly seeking the best solution to the presenting problems. It may not always be the simple writing of prescriptions or the ordering of tests. It is more time-consuming and emotion draining than the traditional, paternalistic, doctor-patient relationship.

Not all doctors are equipped to provide good primary care and not all people wish to receive care in this manner. It is an idealistic concept but does it represent the ideal for medical practice? If one accepts the charges that health care is more expensive than it need be because of inappropriate and wasteful practices, then the answer is yes. I have seen patients overmedicated and overdiagnosed and inappropriately self-referred to the wrong type specialist. If these practices can be eliminated, thus achieving reduction of costs, and at the same time quality of care maintained or improved then one has to favor it. Many believe that the promotion of primary care programs can accomplish this.

County health unit primary care programs • At this point a distinction must be made between the provision of primary care services and a primary care program. The latter requires that the practitioner provide all the patient's medical care within his or her limits of competence and that he or she order and/or arrange for any other services required. The primary care provider then receives reports and advice and utilizes them, with the patient, to reach an acceptable solution to the medical problems. Undoubtedly many doctors provide a lot of primary care for a lot of patients and many different specialists provide comprehensive primary care for a few selected patients. However, it is questionable that very many people have this available to them, even if they should desire it, and especially is this true of poor people.

The obligation of the CPHUs is to assure that certain services are available to those who need them. The CPHUs are not obligated to provide them. So it is with primary care programs. They are expected and encouraged to utilize existing resources where they are available. The services currently being offered

in health departments will be available as resources to fill out a comprehensive program. While the CPHU must add an administration unit for coordination and to provide for accountability, it can subcontract for other clinical elements with existing resources outside the CPHU. Figure 1 illustrates the relationships of the various parts of a comprehensive program. The public and personal health services that appear on the right are presently available in county health units and will continue to provide services to non-primary care clients as well as those who are receiving their care as primary care patients. The necessary clinical additions are primary care practitioners and the ancillary and consultative services.

Program design • Table 1 outlines the services to be included in a comprehensive primary care program. As noted previously, some parts of this package can be and are being provided by the health departments and some may be added or contracted out.

In the RFP, a primary care program was described as requiring accessibility, comprehensiveness, continuity, and coordination. Accessibility was defined as offering patients contact with the progran 24 hours a day, with no actual or perceived barriers to care.

Table 2 lists the requirements designed to assure accessibility, the goal being to eliminate any barriers. Since the program is designed to provide services for all indigents who so desire, there are certain requirements that might not be needed if the population base was different.

Standards have been established by which performance will be evaluated. It is expected that the programs will provide translation assistance in those areas with a large non-English speaking population and, to accomodate the working poor, services will be available during selected nonworking hours. In spite of their economically deprived status, it is expected that they will be afforded privacy and treated in a dignified manner. To provide timely care, programs are required to establish an appointment system and a method to distinguish among emergencies, urgent cases, and routine ones; emergencies being seen immediately, urgent cases the same day, and routine ones as soon as possible. It is also expected that the programs will adhere to a schedule in such a way as to assure that each patient will be evaluated within one hour of appointment time. Quality of care will be further assured by following acute cases until maximum benefit of treatment is reached. Good medical record keeping will demonstrate that consultation reports and abnormal diagnostic studies are acted on and any inpatient treatment is noted. Such records are required to contain, as a minimum, a biographical and medical data base, an acute care record, allergy record, current and past drug treatment list, chronic disease flow charts, and an organized report file. Every program is required to have a formally constituted, active quality assurance program. Accountability will be facilitated by the requirement that certain utilization data be collected and reported regularly.

Table 1. — Services Included in Comprehensive Primary Care Program.

1. Acute episodic care
2. Ancillary services
 - Laboratory
 - Diagnostic radiology
 - Prescription drugs
 - Specialty consultation
3. Chronic disease screening and follow-up
4. Coordination of secondary and tertiary care
5. Health risk appraisal and prevention measures
6. Family planning
7. Twenty-four hour daily availability

Table 2. — Requirements to Assure Accessibility of Medical Care.

1. Extended daily and weekend hours
2. Linguistic translation services
3. Timely care
4. Dignified and private treatment
5. Care continuity

Questions to be answered • Several questions may justifiably be asked, and have been. Is a primary care program, as described, a suitable means of providing medical care to indigents? Is a county public health unit the proper agency to provide and administer such a program? What is the role of the private sector? How do the federally funded Community Health Centers fit into the picture? What is the best method by which to fund this care? Obviously there are no pat answers but some answers will be found.

An idealized and idealistic concept has been described. It is based on a very significant physician-patient relationship. If, as is claimed, there is a poverty subculture manifested by poor education, poor incentive, poor performance, and inferior nutrition, hygiene, and health,[5], then it is a real challenge to the profession to change the poor and inferior to better and good. Only with idealism, tempered with realism can such a challenge be faced.

As to the CPHU being the proper vehicle, there will be differences of opinion. Undoubtedly a hard core of poor people will always exist whose care will necessarily be subsidized with tax dollars. The county health units are presently providing many primary care services using tax dollars. The accountability factor is accepted and the machinery is in place. It is already recognized that there is an obligation to

provide a refuge for poor people who are in need of certain services. It is not a big stretch to extend this to helping them find a "medical home."

The role of the private sector may be more difficult to define and, indeed, there may be different roles, varying with regions of the state and between rural and urban areas. I still believe that most physicians recognize that inherent in belonging to this profession is an obligation to society to contribute their services to those who need them, even when they may be unable to pay. However, in these changing times, dependence upon charity and private philanthropy to do the job is unrealistic. Someone has to pay the bill, and since much of the payment will be from public funds, there will have to be a philanthropic attitude on the part of providers toward the size of the bill. Also, since this will entail at least a little sacrifice, both financial and of practice style, every effort must be made to distribute the load as widely as possible.

In areas where federally funded Community Health Centers exist, they represent an existing vehicle by which to provide at least some of this care. They are already operating under guidelines and requirements similar to those described in this presentation. They are currently experiencing a staffing and financial pinch and simply must foster a cooperative stance with private resources and CPHUs, and it must be a two-way street. An attitude of "we are all in this together" should be the order of the day.

If all other questions find satisfactory answers,

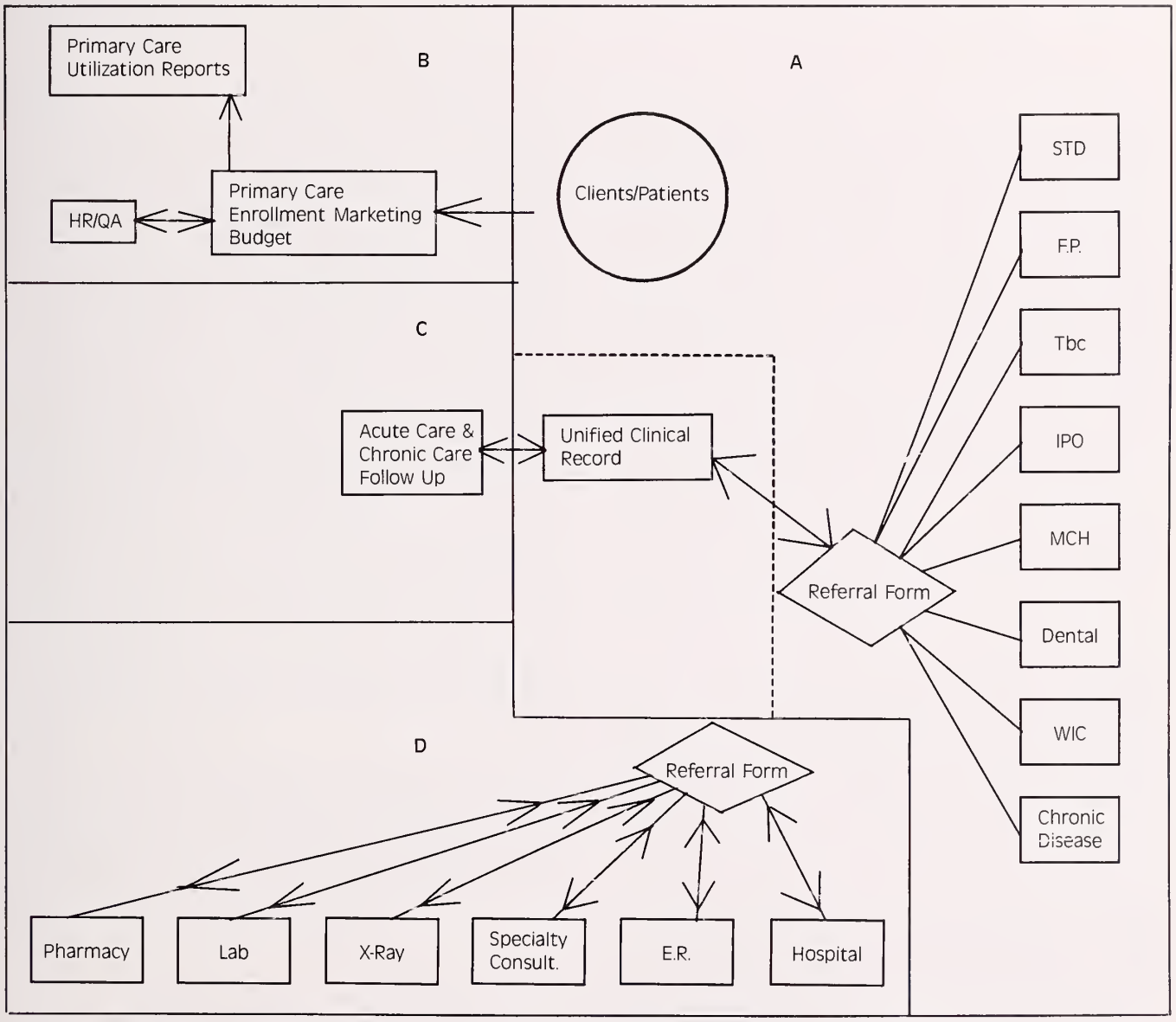


Fig. 1. — Relationships of existing CPHU services and a theoretical comprehensive primary care program. A. Existing CPHU, STD (sexually transmitted disease), FP (family planning), Tbc (tuberculosis), IPO (improved pregnancy outcome), MCH (maternal and child health), WIC (women, infants, and children). B. Additional function to be added. C. Additional function to be added or contracted out. D. Additional function to be contracted out (pharmacy, laboratory, and x-ray may be done in house).

funding will still be a problem and there will probably be developed a plurality of methods, private and public, insurance, capitation and direct subsidy. It has been aptly said by Dr. David Rogers, President of the Robert Wood Johnson Foundation, "It is a social problem and its solution makes economic sense."[6]

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Indigent health care in Florida — a provider's perspective

Husman Khan, M.D.

Health care for the indigent and medically indigent has been a growing concern for many years in Florida. The rapid growth of the state and its service oriented and tourist based economy has atttracted large numbers of working uninsured.

In years past, care for the indigent was mainly delivered by scattered county funded clinics and a few dedicated physicians in their private offices. As the numbers grew, these providers have been overwhelmed and have been unable to cope with the increased demand for services. Many bewildered patients who are in need of non-emergent care bounce around various providers until they are sick enough to be hospitalized. Another group, firmly set in their behavior patterns, now use the emergency rooms of hospitals for all their health care needs. This has resulted in the over-utilization of costly services, lack of continuity of care and the shunting of care from true emergencies.

Lack of cooperation among providers, duplication of services and political turf guarding have all contributed in various measures to the present state of affairs.

Dwindling federal funds and further economic pressures on providers and hospitals engendered by the Diagnosis Related Groups and the introduction of Health Maintenance Organizations have created an atmosphere which can only adversely affect the amount of free care they provide.

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Dr. Khan, an internist, is a member of the FMA Committee on Indigent Care.

Funding for indigent health care has often been described as a "bottomless pit." As health care funds generally become more finite, it is mandatory that we define our goals and work towards them vigorously in order to reap the best returns on expenditures. The Health Care Access Act of 1984 was an innovative piece of legislation. It declared that "access to adequate health care is a right which should be available to all Floridians." In order for us to achieve this goal, it is mandatory that we give clear directions to the legislature on how to appropriately access the target population into Florida's health care system.

The problem of broader-based funding for indigent health care will also need to be addressed in the near future.

As we approach this multifaceted problem, I would like to make the following observations and suggestions for consideration:

1. If we are going to improve access to health care for the indigent population, it is extremely important that we provide incentives to attract more physicians into the delivery system. Many physicians who are willing to help, feel humiliated by the bureacratic red tape involved in collecting the small fee that Medicaid pays. This situation must be corrected quickly if the system is to succeed.
2. We need to create a Professional Office of Health Services at the state level to help the Governor and the legislative body. This office should be staffed by a full-time neutral group of professionals especially recruited to sort through issues and oversee the delivery aspects of care.
3. There is need to have a separate plan for the urban and rural areas of Florida. In the urban areas where many primary care facilities are already in place, these efforts are enhanced and supported. The

proposal as outlined in the Woodruff-Reddick Bill, that Public Medical Assistance Trust Funds be channeled to Public Health Units may be ideal for rural counties, but will not have the desired impact on urban counties. With the exception of a limited few, County Public Health Units have not been in the business of primary care and as such, this will lead to unnecessary delay in developing a comprehensive program for indigent care. Experience over the last year has shown that delay in implementation leads to impatience on the part of the hospitals as they have yet to see an impact on their crowded emergency rooms.

4. In building a comprehensive primary care delivery system, access to secondary and tertiary care is extremely important and as such hospitals must participate. A strong primary care system will divert patients from emergency rooms and will reduce the need for costly hospitalization.

In a state where Medicaid accounts for only 5% of total hospital reimbursement, targeted changes aimed at assisting major Medicaid providers are likely to meet with greater success as opposed to a statewide approach.

5. We need to take a critical look at our primary care facilities and must inject some money into construction of new facilities. These facilities must project the appearance of quality if we are going to modify the behavior of our patients and thus divert them from the "sophisticated" emergency room.

6. The malpractice crisis in Florida today is also a critical issue in caring for the indigent and medically indigent population. Providers have been greatly reluctant to engage in indigent care because this group is perceived to be involved in more litigation. This is a very complex issue and will have to be addressed by society and the legislature.

Finally, as the state develops a comprehensive approach to the problem of indigent health care, I would urge all physicians in Florida, regardless of their area of specialty, expertise or affiliation, to get involved in the indigent care efforts in their area. In a time when there is great chaos in the health care field, there is still some personal satisfaction to be derived from caring for the less fortunate.

● Dr. Khan, 16 S.E. 18th Street, Ft. Lauderdale 33316.

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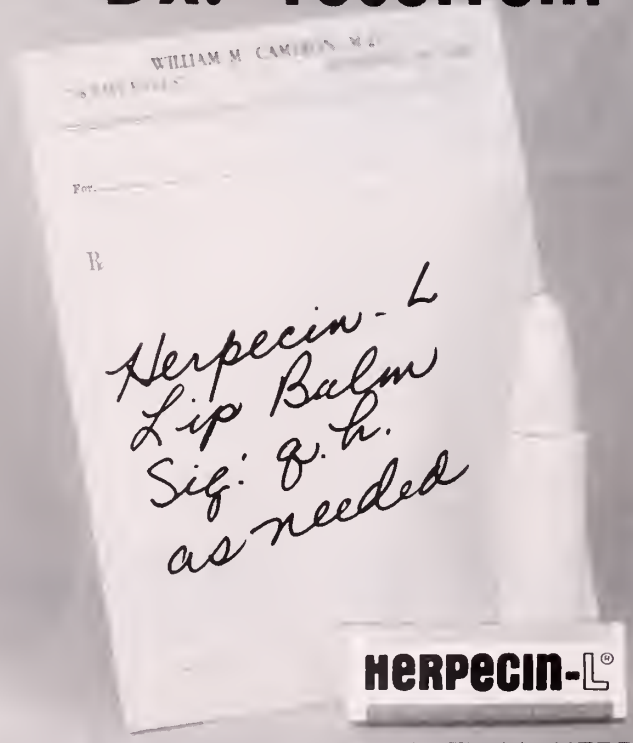
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FLORIDA MEDICAL

DEPARTMENTS

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NOTES & NEWS

Dr. Nunn named President-Elect of SAVS

At a recent meeting of the Southern Association for Vascular Surgery (SAVS) held in Scottsdale, Arizona (January 28-31, 1987), Daniel B. Nunn, M.D., of Jacksonville, was named President-Elect. The SAVS is the regional vascular society for 13 states.

Dr. Nunn was appointed Editor of the *Journal of the Florida Medical Association* in 1980 and served for five years. He currently serves as Contributing Editor.

Dr. Older elected to national post



Jay Justin Older, M.D., has been elected President of the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) for 1987. ASOPRS is composed of physicians and surgeons who devote a significant segment of their professional life to diseases and surgery of the eyelids, orbit, and lacrimal system.

Dr. Older is a Fellow of the American College of Surgeons and a Fellow of the American Academy of Ophthalmology, from which he received an honor award in 1982. As part of his professional career, Dr. Older has authored or co-authored more than 35 scientific articles and textbook chapters. He has recently completed a textbook entitled *Eyelid Tumors: Clinical Diagnosis and Surgical Treatment*, which is scheduled for distribution in March 1987.

Dr. Older currently holds the position of Associate Professor of Ophthalmology, part-time, at the University of South Florida where he is the Director of the Oculoplastic Service. His private practice of ophthalmic plastic surgery is located in Tampa.

New standards for health care in prisons and jails

New standards for health care services in prisons and jails have been published by the National Commission on Correctional Health Care (NCCHC). The new standards revise those originally developed by the American Medical Association and last published in 1979 (prisons) and 1981 (jails).

The standards are recognized as the most authoritative national measurements of reasonably adequate and accessible medical care for inmates of prisons and jails, and are used in the NCCHC's program accrediting the health care systems of correctional facilities.

Included in the new up-to-date revision are sections on administration, personnel, support services, care and treatment, medical records and medical-legal issues, plus sample forms and instructions on policies and procedures, medication administration and control, standing orders and treatment protocols, receiving screening, and discharge summaries. Also, there are new standards on mental health evaluation, infection control, suicide prevention, sexual assault, staffing levels, clinic space, communicable diseases and isolation, and care of the mentally ill and physically or developmentally disabled inmates.

Requests for copies ($15.00) or for order information should be addressed to the National Commission on Correctional Health Care, Box 3500, 2000 North Racine, Chicago, IL 60614 (Telephone: 312-528-0818).

Funding continued for community health care programs

The Hospital Research and Educational Trust (Trust), the research and development affiliate of the American Hospital Association, has recently received a $235,140 grant from The Robert Wood Johnson Foundation to continue administering Community Programs for Affordable Health Care (CPAHC). A project promoting the development of community-based health care cost-containment programs, CPAHC is overseen by a national advisory committee chaired by Professor John T. Dunlop of Harvard University.

Since its inception in 1982, the $15.2 million project, funded by RWJF and cosponsored by the

American Hospital Association and the Blue Cross and Blue Shield Associations, has provided matching grants of as much as $100,000 to 16 communities to plan comprehensive, multiyear, communitywide programs aimed at restraining local health care expenditures. Now in its second stage, 11 communities nationwide have been awarded grants of up to $1.5 million to implement these plans.

According to Linda Hill-Chinn, newly appointed CPAHC senior program consultant, the grant will allow project work over the next year to focus on reviewing communities' progress in implementing programs, supporting CPAHC national advisory committee review and recommendation to RWJF of communities appropriate for continued funding and getting the word on successful programs out to other communities.

The major objective of CPAHC is to foster cooperative interaction among purchasers, payers and providers. To receive funding, a community must be able to mobilize its hospitals, third-party payers, major employers and unions to participate in program planning and implementation.

"One of the challenges of CPAHC program," Hill-Chinn said, "was requiring these groups to work together. Each has a different objective, and a level of trust had to be developed among the leadership of the various groups so that decisions could be made. However, in communities that have achieved that trust, major strides can be made to improve cost effectiveness and access to the health system."

Under the grant, the Trust offers technical assistance not only for communities receiving development or implementation grants, but also for other communities interested in developing similar programs. "Several very successful programs have been developed with the grant support," Hill-Chinn said, "and we need to let other communities know about them."

Some of the CPAHC programs include:

- a community-rated benefit plan in Tulsa, OK, in which a local HMO and preferred provider organization charge small and large employers the same rate to provide employees with coverage, thereby subsidizing indigent care more cost effectively;
- a locally developed pre-admission review program, including a substance abuse and mental health component and a comprehensive program of care for the elderly in Mecklenburg, NC;
- a project in Topeka, KS, to establish a small urban/rural physician and hospital financing and delivery network;
- projects in Iowa to reduce variations in physician practice patterns, establish rural alternative delivery systems and implement a capitated comprehensive workers compensation program; and
- a project in Worcester, MA to develop competitive health plans which compete according to rules established by the community.

Perhaps the most important task assigned under the grant is encouraging communities to create innovative models that can be used in other locations. "Each community is working to develop something really important that will be a breakthrough for use by other communities as well," Hill-Chinn said.

Since 1972, The Robert Wood Johnson Foundation, located near Princeton, NJ, has made more than 2,500 grants totaling almost three-quarters of a billion dollars to a variety of institutions and groups working to improve health care in the United States.

DEAN'S MESSAGE

On indigent care

The Spring of 1987 may become a key chapter in the history of medical care in the State of Florida. In the flurry of activity of competitiveness, oversupply, paraprofessionals, certificates of need, radical changes in reimbursement, discount medicine, and storefront medicine, the real needs of the medically indigent have not been addressed and, indeed, have been forgotten.

Some years ago, the state's Medicaid program attempted to grapple with the issue. With inflation and no significant new resources committed to the program, an unfair dichotomy has evolved. Medicaid first does not provide all medically indigent with access. Secondly, while hospitals are reimbursed at a rate approaching 80% of costs, physician reimbursement is less than 20%. Hence, there is no incentive for the primary providers of medical care — the physicians — to treat large numbers of medically indigent. Hospitals are not under the same fiscal restraints because of the higher rate of reimbursement.

The 1985 Legislature passed the Health Care Consumer Protection and Awareness Act which taxes hospitals 1.5% of net operating revenue. The proceeds from this tax have been placed in a trust fund which now is almost $150 million. The intent was to distribute these monies back to hospitals which provide a significant amount of uncompensated care. To date, no money has been distributed. It remains in Tallahassee earning interest. This "sick tax" was not levied on physician's fees and has no provision to be distributed to physicians who provide uncompensated care.

At last, there is an increasing tide of interest among all sectors of society in our state regarding the fate of the medically indigent. A comprehensive

analysis, commissioned by the Hospital Cost Containment Board, has been completed. This analysis was done to assist the state in developing a methodology to distribute the monies collected under the Health Care Consumer Protection and Awareness Act.

In the near future, an analysis of uncompensated care delivered by physicians in the state will be completed by the Center for Health Policy at the University of Florida. This study was commissioned by the Florida Medical Association.

Therefore, a complete and comprehensive picture of the total amount of uncompensated care the providers of medical care in this state provide will be available.

Finally, a bill (HB3) by Representatives Woodruff (R) and Reddick (D) has been pre-filed for the 1987 Legislature. This bill repeals the sick tax and essentially makes indigent care an issue for society to provide. This bill would increase by 0.5% the existing tax rate on rental tax, admissions tax, and sales tax.

To assist in the solution of this increasing problem will require the support of the physicians in our state. The famous pathologist of the 19th century, Rudolf Virchow, once wrote:

"The physicians are the natural attorneys of the poor . . . "

William B. Deal, M.D.
Associate Vice president for Clinical Affairs and
Dean, College of Medicine
University of Florida
Gainesville

ENCORES!

Relative values/relative needs

It has often been said that everything is relative. Sometimes it takes standing outside one's self, or one's niche, or even one's country to really appreciate how true this saying really is. The experience of a barium enema for instance is relative to which end of the nozzle one is on. There is no doubt in my mind that we physicians would be a lot more empathetic, and would order a lot less invasive tests on our patients if we were more often on the "done to" end of matters. Too often we take our knowledge for granted. Relative to our day-to-day experience and education, even the most complex, and technically challenging procedures are ho-hum. Yet, to the uninitiated victim of disease the prospect of what lies ahead may be incomprehensibly frightening.

Our medical concerns are likewise relative to what challenges we face today, and to what our resources are. Outside of cursory concern regarding the AIDS epidemic, our most likely conversations revolve around the cost of malpractice insurance, or what new third-party payer has us by the throat. The hospitals vie to provide the newest technology or the fanciest wallpaper. And patients shop for the best health care bargain, the coziest birthing room, or the doctor that will give them what they want, when and where they want it. What we have here in the good old U.S.A. is a relative Glut of everything.

Now you are probably wondering where J.T. came upon this revelation of enlightenment. Admittedly in the quiet morning shadow of Mount Kilimanjaro.

In November I spent two unforgettable weeks in the country of Kenya, on the dark continent. Not only did I witness the spectacle and grandeur of this secluded place with its herds of uncaged animals roaming over infinite landscapes, but I was also privileged to visit hospitals and clinics staffed with dedicated professionals stretching their meager resources to the max. Our conversations left me with a renewed image of "physician." The image that got me into this profession in the first place. Here the topic of conversation centered around treating disease, and caring for people.

The dilemmas were how to provide immunization, or follow-up medication for wandering nomadic tribes like the proud Maasai. Or where to obtain an antibiotic other than penicillin or tetracycline to treat a resistant organism. There were children dying of measles and Leishmaniasis. And a ward of Lepers in all stages of their disease. There were newly acquired diagnostic instruments sitting quietly in hallways because there were no technicians to service them. There were women laboring two-to-a-bed (in complete silence) without the benefit of electronic fetal monitoring or analgesia. There were vaginal breech births.

As you can see, relative to our standards, they were lacking a great deal. Yet what they did not lack was determination and a great knack to make the best of what they had. I never saw the shadow of despair on a doctor's face, but the lines of fatigue were more difficult to hide.

More than anything, I think I was struck by the endless patience that pierced through the even more endless obstacles that the Kenyan's face (and theirs is one of the more progressive countries on the continent). More than once I heard Nelson, our driver, remark "In Africa, cannot be in too much hurry — must be patient, and wait." I am certain that if he ever came to visit us here he would think we "in too much hurry" all the time. Beyond our impatience I am sure he would find it overwhelmingly difficult to comprehend the general discontent that flows through the veins of our society — especially in light of all the

excesses that surround us. But then it has often been said that everything is relative.

I shall be forever be indebted to Nelson, a wise and gracious black man from half a world away with less than a fraction of my education and means who generously gave his simple, but insightful thoughts on getting along in this world. Thankfully I have not been the same since.

John Taylor, M.D.
Tallahassee

Reprinted with permission from *CAP SCAN*, the newsletter of the Capital Medical Society, January 1987, No. 152, pg. 7.

A clinician's adventures in medicine: is aspartame (NutraSweet®) safe?

Aspartame is a nutritive sweetener approved by the Food and Drug Administration (FDA) in 1982.[1] Its brand names include NutraSweet® , Crystal Light® , and Equal® . This compound consists of two amino acids (L-phenylalanine and L-aspartic acid) and methyl alcohol. It is currently being consumed by an estimated 100 million persons in the United States.

The public and the medical profession have been assured by the Council on Scientific Affairs of the American Medical Association,[2] the Centers for Disease Control (CDC), and a host of other organizations and regulatory bodies that aspartame is "completely safe." The CDC regards most consumer complaints as an "unusual sensitivity to the product."[3] The manufacturer offers a bibliography of more than 100 published studies as evidence of safety.

Evolving doubts ● I challenge the alleged safety of aspartame on the basis of many personal observations, a nationwide study of detailed data on 496 aspartame reactors, and considerable ongoing research by myself and others. Furthermore, I raised the possibility that this substance may consitute an imminent public-health hazard during a recent address to the annual meeting of the Southern Medical Association.[4]

● More than 10,000 complaints have been directed by consumers to myself, the FDA, CDC, manufacturer, other interested investigators, and consumer organizations.

● The causative role of aspartame has been shown by (a) the improvement or disappearance of symptoms and signs within days or weeks after stopping aspartame, and (b) their prompt recurrence (within hours or days) after resuming such products. The latter included self-testing on numerous occasions, inadvertent ingestion, or formal rechallenge. These sequences were impressive in patients experiencing grand mal convulsions, headaches, itching, rashes, and severe gastrointestinal reactions.

● Other physicians have documented similar reactions . . . either as case reports or in personal communications to me.

Clinical data on 496 reactors ● The general data on 496 aspartame reactors are summarized in Table 1. They included 115 patients and aspartame reactors who were personally interviewed, and 381 persons who detailed their adverse effects in a nine-page questionnaire survey. The names of the latter were provided by Aspartame Victims and Their Friends (courtesy of Mrs. Shannon Roth), the Community Nutrition Institute (courtesy of Mr. Rod Leonard), and Dr. Woodrow Monte of Arizona State University.

The most frequent and severe reactions to aspartame are listed in Table 2. The majority of reactors experienced multiple features.

Review of the general data — gender ● There was a 3:1 preponderance of female aspartame reactors. Many influences may be operative — including their increased risk for severe depression, allergies and diabetes, the phenylalaninemia noted in women with iron deficiency, and the greater insulin responses to oral or intravenous phenylalanine and other amino acids in healthy nonobese females.[5]

Table 1. — General Data on 496 Aspartame Reactors

Gender		
Males		127 (26%)
Personal series	— 45 of 115	(39%)
"Aspartame victims" Community Nutrition Institute	— 64 of 291	(22%)
Dr. W. Monte	— 14 of 67	(21%)
	— 4 of 23	(17%)
Females		369 (74%)
Personal series	— 70 of 115	(61%)
"Aspartame Victims" Community Nutrition Institute	—227 of 291	(78%)
Dr. W. Monte	— 53 of 67	(79%)
	— 19 of 23	(83%)
Age range		
From 2 to 92 (x2) years the majority in their 20s to 50s, averaging 45 years		
Familial Incidence		108 families (22%)
	2 reactor members — 80	
	3 reactor members — 25	
	4 reactor members — 2	
	5 reactor members — 1	

Table 2. — Major Side Effects in 496 Aspartame Reactors

Eye	
Decreased vision and/or other eye problems (blurring, "bright flashes," tunnel vision)	118 (24%)
Pain (one or both eyes)	44 (9%)
Decreased tears, trouble with contact lens, or both	12 (2%)
Blindness (one or both eyes)	12 (2%)
Ear	
Tinnitus ("ringing" or "buzzing")	63 (13%)
Severe intolerance for noise	38 (8%)
Marked impairment of hearing	23 (5%)
Neurologic	
Headaches	225 (45%)
Dizziness, unsteadiness, or both	195 (39%)
Confusion, memory loss, or both	140 (28%)
Convulsions (grand mal epileptic attacks)	73 (28%)
Petit mal attacks and "absences"	18 (4%)
Severe drowsiness and sleepiness	81 (16%)
Paresthesias ("pins and needles," and "tingling") or numbness of the limbs	68 (14%)
Severe slurring of speech	55 (11%)
Severe "hyperactivity" and "restless legs"	39 (8%)
Atypical facial pain	33 (7%)
Severe tremors	41 (8%)
Psychologic — Psychiatric	
Severe depression	125 (25%)
"Extreme irritability"	109 (22%)
"Severe anxiety attacks"	86 (17%)
"Marked personality changes"	76 (15%)
Recent "severe insomnia"	64 (13%)
"Severe aggravation of phobias"	32 (7%)
Chest	
Palpitations, tachycardia (rapid heart action), or both	72 (15%)
"Shortness of breath"	42 (9%)
Atypical chest pain	34 (7%)
Recent hypertension (high blood pressure)	23 (6%)
Gastrointestinal	
Nausea	68 (14%)
Diarrhea	63 (13%)
Associated gross blood in the stools	12 (2%)
Abdominal pain	62 (13%)
Pain on swallowing	22 (4%)
Skin and Allergies	
Severe itching without a rash	38 (8%)
Severe lip and mouth reactions	23 (5%)
Urticaria (hives)	21 (4%)
Other eruptions	42 (9%)
Aggravation of respiratory allergies	10 (2%)
Endocrine and Metabolic	
Menstrual changes	40 (8%)
Severe reduction or cessation of periods	18 (4%)
Marked thinning or loss of the hair	31 (6%)
Marked weight loss	22 (4%)
Paradoxic weight gain	29 (6%)
Aggravated hypoglycemia (low blood sugar)	20 (4%)
Loss of control of diabetes	15 (3%)
Other	
Frequency of voiding (day and night), burning on urination (dysuria), or both	60 (12%)
Excessive thirst	52 (10%)
"Bloat"	50 (10%)
Severe joint pains	48 (10%)
Fluid retention and leg swelling	18 (4%)
Increased susceptibility to infection	6 (1%)

Latent period • Latent periods of from several weeks to several months between the initial consumption or increased intake of aspartame and the onset of several symptoms were most common. Others reacted almost immediately.

Aspartame intake • Many consumed prodigious amounts of aspartame, especially during hot weather. On the other hand, some experienced convulsions, headache or other severe symptoms after chewing an aspartame-sweetened gum, analgesic or vitamin, or while breast-feeding as the mother drank an aspartame beverage.

Pathophysiology • Aspartame reactions may be caused by the compound itself, any of its three components (phenylalanine, aspartic acid, methyl alcohol), toxic breakdown products (10 identified to date), or combinations thereof. They often occurred in association with severe caloric restriction and excessive exercise to lose weight.

Damage to the retina or optic nerves is probably due to high methyl alcohol concentrations. Aspartame yields about 10% methanol by weight. Humans, unlike most animals, cannot efficiently metabolize it.

Many other metabolic and physiologic disturbances seem to explain the cited complications. Only a few will be listed.

- High concentrations of phenylalanine and aspartame occur in the brain, unlike the modest levels following protein intake.
- Aspartame alters the function of major amino acid-derived neurotransmitters — especially in obese persons and after increased carbohydrate intake.
- Phenylalanine stimulates increased release of insulin and growth hormone.[6,7]
- The ambiguous signals to the satiety center following aspartame intake[8] may result either in increased food consumption or severe anorexia.

Clinical implications • Physicians must question patients who present with the disorders listed in Table 2 about aspartame use. If it is being consumed, a brief trial of abstinence should be recommended before reflexively requesting consultations and expensive tests. Failure to appreciate the underlying role of aspartame has resulted in unnecessary medical costs . . . especially CT scans and NMR studies of the brain, electroencephlograms, and multiple hospitalizations.

The following caveats reflect my clinical experience:

- Inquiry about aspartame use is necessary in every patient with an unresolved allergic, dermatologic, gastrointestinal or metabolic problem.
- The physician must not attribute visual, neurologic or bowel problems in diabetics to a

presumed retinopathy or neuropathy until the response to aspartame cessation is evaluated.

- Cataract surgery ought to be deferred at least one month in heavy aspartame users for symptomatic evaluation.
- Patients presenting with seizures, headache, facial or eye pain, the Meniere syndrome, depression, and a host of neuropsychiatric problems of undetermined cause, or who fail to respond to conventional therapy, must be asked about aspartame use — especially before recommending invasive studies such as cerebral arteriography.
- Younger patients who express concern about having "early Alzheimer's disease" because of recent confusion and memory loss ought to be observed at least one month after stopping aspartame before such a definitive diagnosis is considered.
- A D&C or hysterectomy should be deferred for comparable obervation in women consuming considerable aspartame who have heavier or more frequent periods.

The urgent need for research and education • Physicians and the public must be made aware of such concern. High-risk groups deserve special emphasis. They include pregnant and lactating women, young children, older persons, patients having iron-deficiency anemia, liver disease, kidney impairment, migraine, hypoglycemia, diabetes mellitus and hypothyroidism, individuals with prior alcoholism or drug abuse, those at risk for phenlketonuria, and patients taking drugs that might interact with phenylalanine (e.g., L-dopa, monoamine oxidase inhibitors, alpha-methyldopa).

Aspartame was licensed for general use in spite of objections by three FDA scientists . . . especially brain tumors and birth defects. They still must be addressed. It is appropriate to recall that a longer period transpired before thalidomide was proven to be a cause of birth defects.

On the basis of mounting clinical and investigational observations, I also am concerned that aspartame might cause, accelerate or aggravate Alzheimer's disease, Parkinsonism, depression, intellectual deterioration, and other neuropsychiatric disorders.

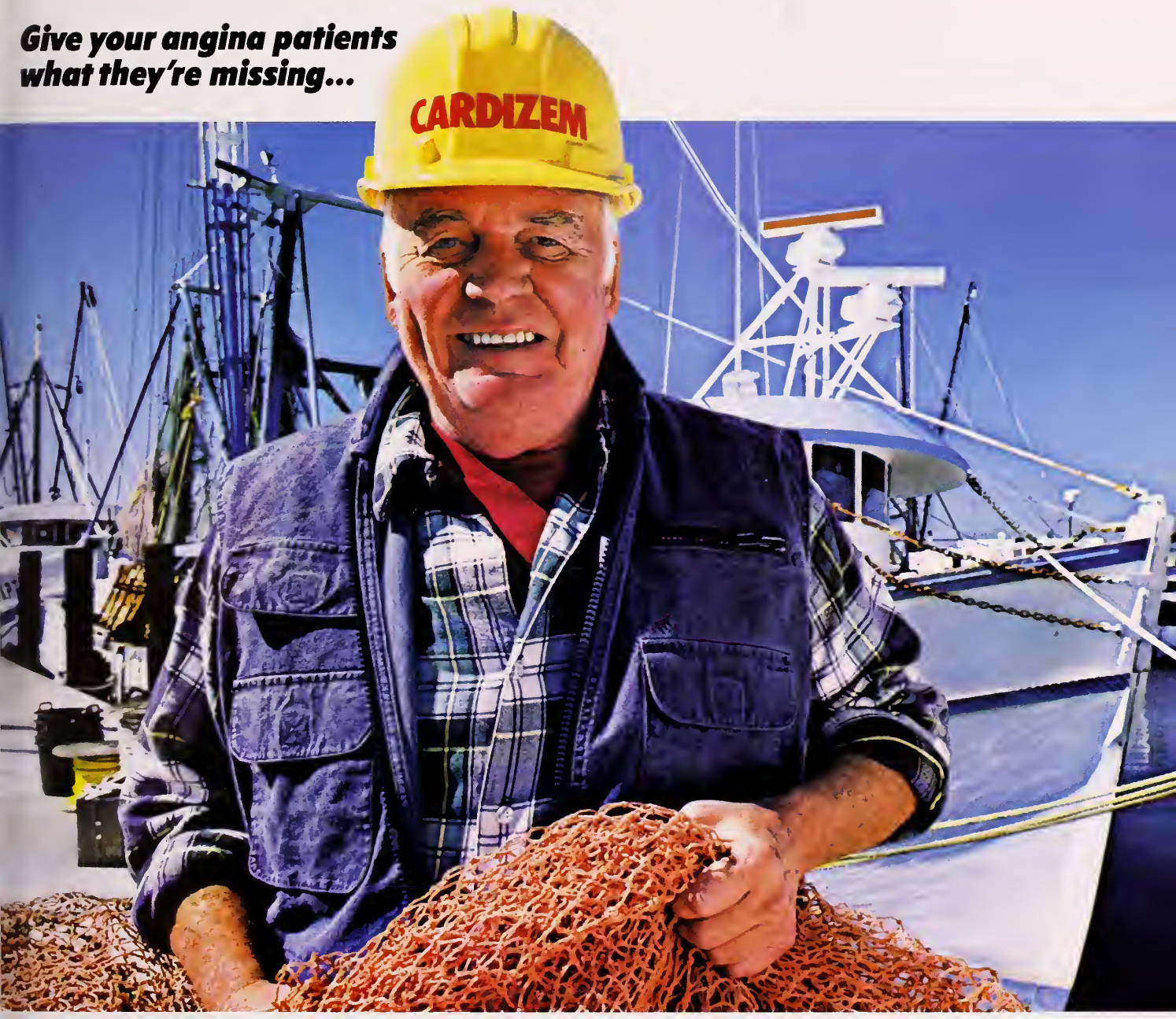
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West Palm Beach

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Give your angina patients what they're missing...



CARDIZEM®: FEW SIDE EFFECTS

diltiazem HCl/Marion

- ***Antianginal action includes dilatation of coronary arteries, a decrease in vascular resistance/afterload, and a reduction in heart rate***
- ***Proven efficacy when used alone in angina[1]***
- ***Compatible with other antianginals[2,3*]***
- ***A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD[4,5]***

***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.



CARDIZEM® diltiazem HCl/Marion

FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

60 mg tid or qid

Brief Summary
Professional Use Information

CARDIZEM®
(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/posthatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

See complete Professional Use Information before prescribing.

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ZOVIRAX®
(acyclovir)
CAPSULES

Prevent genital herpes recurrences month after month with daily therapy.

(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)

Please see last page of this advertisement for brief summary of prescribing information.

ZOVIRAX® (acyclovir) CAPSULES

Help free your patients from recurrences.

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks—month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

Please see brief summary of prescribing information on next page.



Prevent recurrences month after month*

ZOVIRAX® (acyclovir) CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies,. the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 ml/min/1.73/m^2.

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200"- Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

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Managing hypertension: the complete program developed by the Cleveland Clinic

By James V. Warren, M.D., and Genell J. Subak-Sharpe, 167 pages. Price $14.95. Doubleday & Company, Inc., Garden City, New York.

Following *Surviving Your Heart Attack* and *Living With Diabetes*, this book is third in the Frontiers in Medicine Series. It is directed to the patient with the disease or lay public, not to the physician. Only occasionally flirting with esoterica such as the renin-angiotension-aldosterone system which could be confusing to the non-physician, the book is generally well organized, easy to read and has an abundance of helpful advice — for example, emphasis on salt restriction, weight reduction programs with diets, a stop smoking section. The book is well balanced and informative; it emphasizes the serious nature of hypertension, the generally life-long project of control rather than cure in a non-alarming, optimistic and up-beat fashion. It stresses the responsibility and important role of the patient in determining his own treatment result. There are good sections on relaxation methods and home blood pressure monitoring. The authors are practical enough to include brand name drugs as well as generics.

Emanating from the Cleveland Clinic, a bastion of research and treatment in hypertension, and dedicated to Dr. Irvine Page, any physician can confidently recommend this short book to his intelligent hypertensive patient who is seriously interested in understanding and controlling his disease.

Richard W. Snodgrass, M.D., F.A.C.P.
Daytona Beach

- Dr. Snodgrass is in the private practice of internal medicine. He is a past-president, Florida Society of Internal Medicine and Council Member, Florida Chapter, American College of Physicians.



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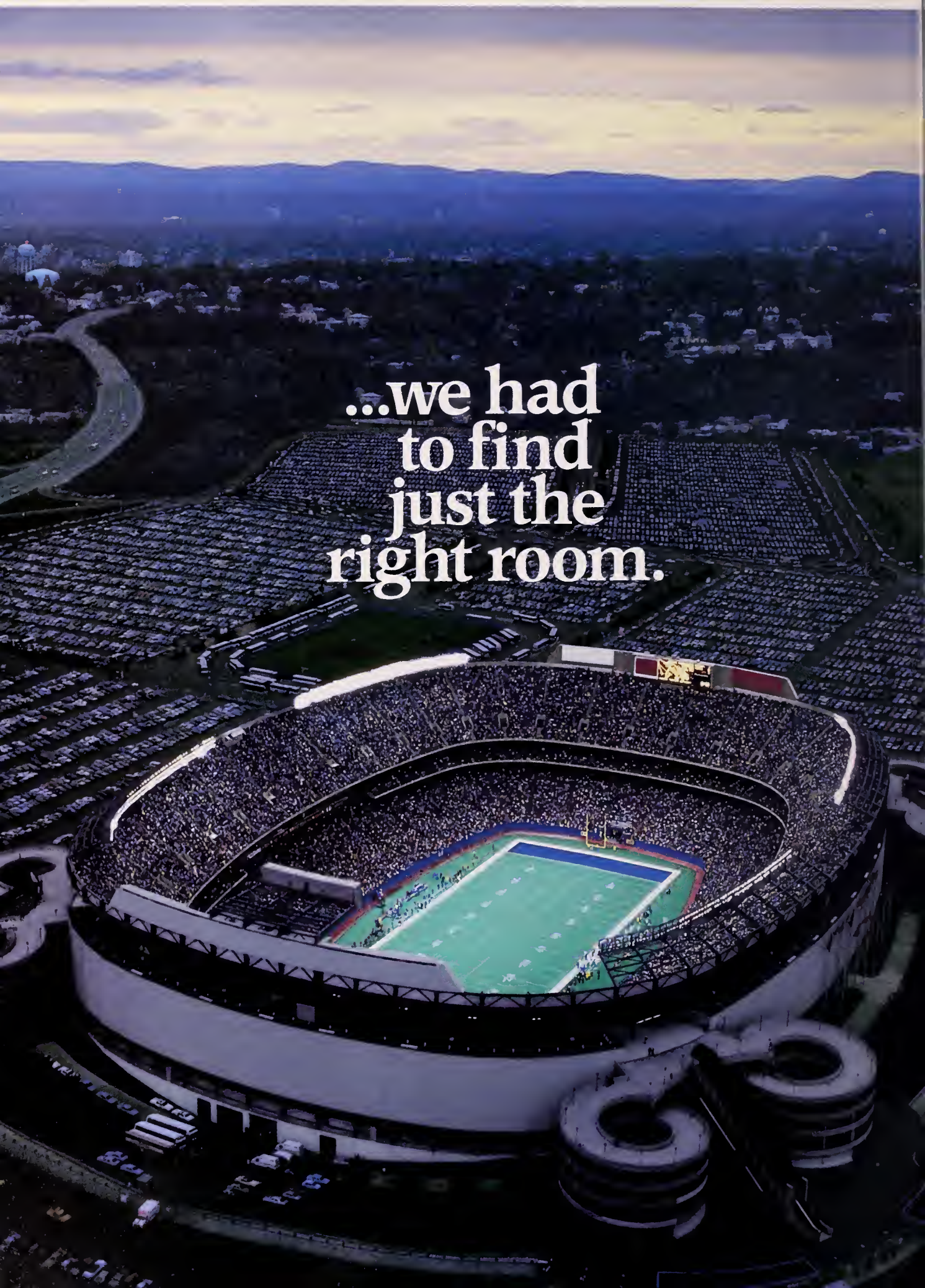
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To show you how many hypertensives stayed on INDERAL® LA (PROPRANOLOL HCl) after a major nationwide trial...




...we had
to find
just the
right room.

60,073 patients (90%) who started on INDERAL® LA stayed on INDERAL LA.[1*]

Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.
A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.

Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were controlled merely with the addition of a diuretic to INDERAL LA.

For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

Control, comfort, and compliance

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

Please see next page for brief summary of prescribing information

The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

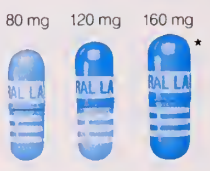
ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES

80 mg 120 mg 160 mg



INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories

REFERENCES:

1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321-1323.

6412/187

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Specify "Dispense as written" for the original hydrocodone analgesic.

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

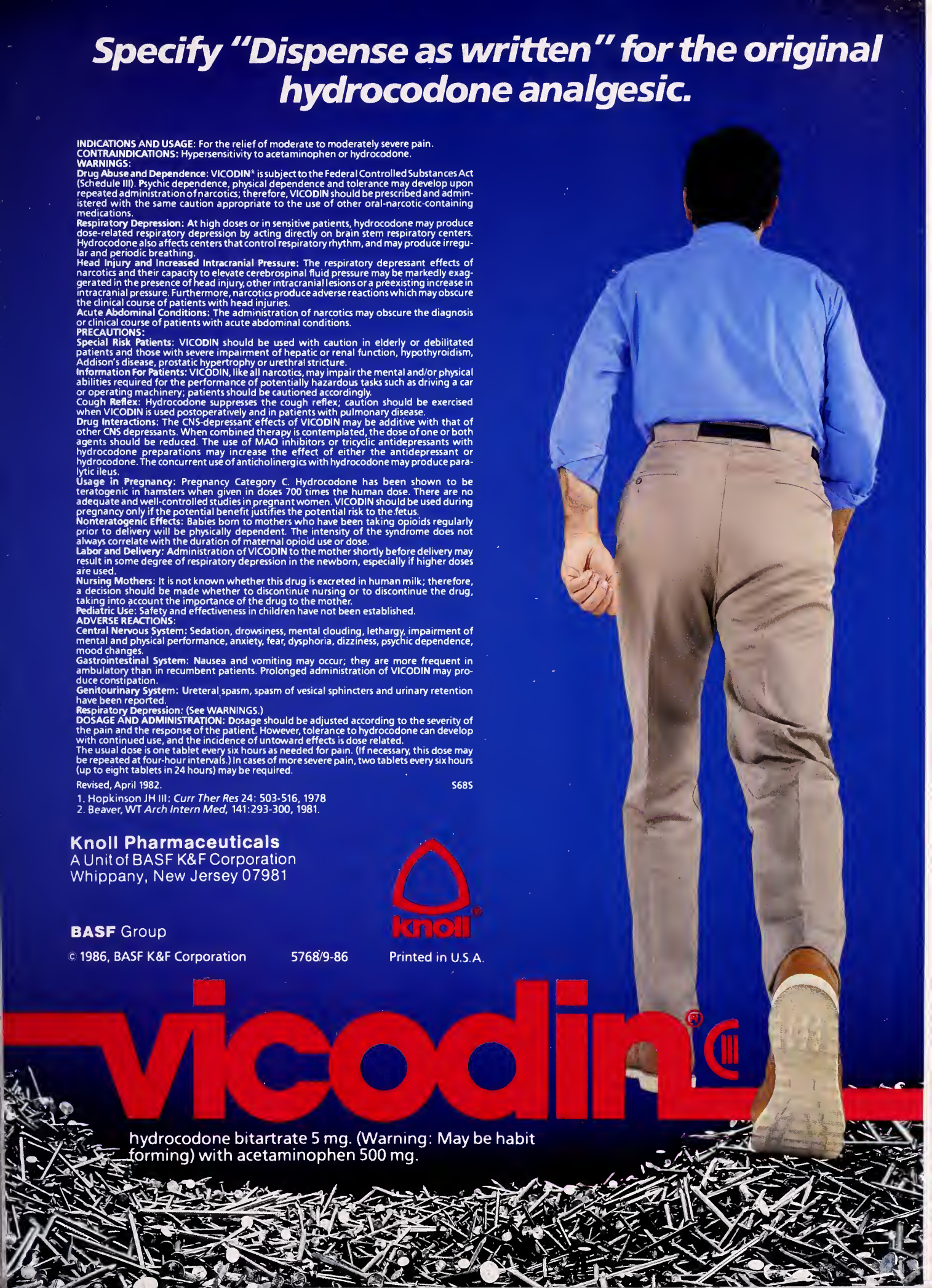
Revised, April 1982. S68S

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	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

- Vicodin offers: less nausea, less sedation, less constipation.

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Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Interplast South brightens a child's future

The future becomes dim for children facing an uncertain development due to uncorrected congenital defects or deformities. The Florida Medical Association Auxiliary has been instrumental in providing the means for these children to have corrective surgery, through its assistance to Interplast South.

On October 8, a contingent of 11 South Florida doctors and nurses from Interplast South flew to San Pedro Sula, Honduras. Joined by another 13 from around the U.S. and Canada, this group performed 100 reconstructive plastic surgery procedures over a period of eight days.

The majority of these patients were children with cleft lip and palate deformities who had traveled some distance to the Leonardo Martinez Hospital in San Pedro Sula.

Close to 200 patients were seen the first day in clinic, although many more were examined as they arrived throughout the eight day period.

This ongoing program is sponsored by Interplast, an all volunteer organization which has provided needed surgery to thousands of children in developing countries for almost 20 years.

Interplast South, Inc., is an outgrowth of the parent organization, Interplast, Inc. Started in 1976, Interplast South has participated in many trips to foreign countries as well as providing surgery in the Fort Lauderdale area for children who required more complicated operations that could not be performed in their home countries. Funds for these operations have been provided largely by the Florida Medical Association.

All of the volunteer participants of this most recent trip acknowledged that they gained as much from the trip as their patients. "While the operations were performed in less than ideal settings, the good feelings generated by helping these children reminded us of the fundamental reasons we all went into medicine." This comment was heard from many of the health professionals involved in this humanitarian effort.

Future plans include twice a year trips to Honduras. Medical teams going to underdeveloped nations to brighten a child's future need our financial support. Contributions help defray not only the travel expenses of the members of the team, but also assist with expenses for travel of children to the United States for treatment not possible in their home countries.

Severely burned victims are taken to the Shrine BurnCenter in Houston. Children needing multiple procedures, complicated surgery, or who are not physically able to have surgery while the team is present, may also be brought to the United States for treatment.

At the Leadership Conference in Tampa in March, items will be available for sale such as plastic non-spillable mugs, FMA-A logo umbrellas, and an opportunity for a Pot of Gold. Information or donations will be greatly appreciated, and may be sent to the FMA-A International Health Chairman, Mrs. Terri Carver, 1509 S.E. 43rd Terrace, Cape Coral, Florida 33904.

The Florida Medical Association Auxiliary provides funds to help Interplast South continue its operations. Interplast South is a non-profit organization and all contributions are tax deductible to the extent provided by law. The purpose of the Auxiliary fundraisers is to assist with the continuity of these needed medical procedures for children who might otherwise have a very dim future. With the help of our members and all interested persons, we can make the future brighter for children of underdeveloped nations.

In the United States, children with congenital

defects or deformities are all eligible for public funds for corrective procedures. Children with similar problems who live in other less fortunate countries of the world may lack the opportunity for a bright future unless we continue this vital work. Won't you help? All FMA Auxiliary proceeds from International Health for Interplast South go directly to this non-profit group. Please help us reach our goal of $8,000. Brighten a child's future!

Terri Carver
International Health Chairman, FMA-A
Cape Coral



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Each year, millions of people learn water safety at a Red Cross class.
Unfortunately, millions of others couldn't spare the time. What about you?

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Deaths

AHMANN, CHESTER F, Gainesville; born December 6, 1897; University of Tennessee, 1935; died July 11, 1986.

ANDERSON, HORACE M., Sapphire, N.C.; born, January 18, 1918; Emory University, 1943; died March 3, 1986.

AZADA, ANGELITO G., Auburndale; born October 1, 1935; Far Eastern University, Manila, 1963; member AMA; died December 25, 1985.

BEVIS, VICTOR S., Miami; born September 7, 1942; University of Miami, 1969; member AMA; died October 13, 1986.

BIRELY, BEVERLY R., Ft. Lauderdale; born May 2, 1923; University of Maryland, 1951; died 1986.

BURBACHER, CHARLES R., Miami; born April 16, 1910; University of Ohio, 1934; died May 7, 1986.

CALDWELL, JOHN M., Miami; born November 29, 1904; University of Georgia, 1928; died 1986.

CALHOUN, LAURIE L., Ocean Springs, MS; born February 17, 1954; University of Mississippi, 1979; member AMA; died October 10, 1986.

CAVA, EDWARD E., Miami; born January 23, 1927; University of Louisville, Kentucky, 1947; member AMA; died June 19, 1986.

COHEN, ALAN B., Miami; born April 19, 1928; Tulane University, 1954; member AMA; died November 1986.

CORWIN III, JAMES H., Jacksonville; born November 2, 1952; Jefferson Medical College, Philadelphia, 1978; died April 27, 1986.

CRESPO, ARTAGNAN, St. Petersburg; born December 28, 1928; University of Havana, Cuba, 1960; died June 25, 1986.

DELOS SANTOS, JOSEPH, Ormond Beach; born November 26, 1945; University of Santo Tomas, Manila, 1970; member AMA; died February 1986.

DIAZ-RODRIGUEZ, ANTONIO, Miami; born June 23, 1926; University of Havana, Cuba, 1950.

DUFF, ROLAND D., Haines City; born 1919; Medical College of Alabama, 1951; died September 6, 1985.

ENZOR, SR., RHETT E., Fort Walton Beach; born April 23, 1907; Baylor, 1932; member AMA; died July 28, 1986.

FERAYORNI, RICHARD R., Ft. Lauderdale; born September 3, 1919; Long Island College of Medicine, 1943; member AMA; died June 1, 1985.

FEUERMAN, BARRY, Miami; born July 30, 1936; New York Medical College, 1962; died July 15, 1986.

FLORENCE, HYMAN, Miami; born April 17, 1930; Baylor, 1955; member AMA; died August 20, 1986.

FOUST, BETTY JEAN, Rochester, MN; born January 8, 1931; Indiana University, 1957; member AMA.

FOX, EDWARD F., Miami; born August 18, 1903; University of Tennessee, 1932; member AMA; died November 30, 1986.

FREDERICK, ALBERT, St. Petersburg; born July 20, 1907; University of Pennsylvania, 1933; member AMA; died July 8, 1986.

FREEMAN, JULES, Coral Springs; born June 12, 1908; New York University, 1935; died July 5, 1986.

GARCIA-QUINTANA, MIGUEL, Miami; born March 22, 1916; University of Havana, Cuba, 1944.

GLATTAUER, ALFRED, Miami; born April 18, 1915; Zurich, 1940.

GOLDMAN, MILTON, Miami; born February 14, 1902; Pittsburgh, 1927.

GORDON, LIONEL, Pompano Beach; born June 6, 1916; McGill University, Montreal, 1940; died June 16, 1986.

GREENE, JOHN R., Charlotte Harbor; born September 7, 1920; Ohio State University, 1953; died July 28, 1986.

HELLER, NATHAN, Hollywood; born June 26, 1922; University of Western Ontario, 1949; died May 5, 1986.

HEWSON, GEORGE, Naples; born December 5, 1908; St. Louis University, 1933; member AMA; died October 12, 1986.

HICKMAN, JACK W., Tampa; born June 3, 1931; Indiana University, 1955; member AMA; died October 12, 1986.

HODGE, EDGAR, B., Lakeland; born April 19, 1921; University of Texas, 1952; member AMA; died August 21, 1986.

JIMENEZ, JUAN A., Miami; born October 28, 1908; Havana University, Cuba, 1938; died August 26, 1986.

JORDON, OTIS L., Fort Myers; born May 20, 1904; Louisiana State University, 1935; died September 23, 1986.

KOGER, EDWARD R., Orlando; born March 29, 1930; Duke University, 1956; member AMA; died August 26, 1986.

KELLER, THEODORE C., Miami; born July 10, 1915; Tulane University, 1942.

KING, ALBERT G., Lakeland; born September 7, 1922; Temple University, 1947; member AMA; died August 31, 1986.

LARIOS, OSCAR H., Miami; born October 24, 1951; University of Nicaragua, 1976; member AMA; died October 11, 1986.

MANCUSI-UNGARO, LUDWIG E., Miami; born February 3, 1916; Long Island College of Medicine, 1940; member AMA; died July 30, 1986.

MANRODT, SPENCER C., Melbourne; born February 3, 1918; University of Rochester, 1952; member AMA; died October 30, 1986.

MANSON, A. MACKENZIE, Jacksonville; born September 1, 1910; University of Tulane, 1937; member AMA; died June, 1986.

MATEEFF, DELEON, St. Petersburg; born May 18, 1920; University of Michigan, 1958; member AMA; died March 25, 1986.

MCCOY, DONALD L., Gainesville; born July 11, 1932; University of Kansas, 1957; member AMA; died November 20, 1986.

MCKAIG, MALCOLM C., Largo; born July 31, 1910; Georgetown University, 1937; member AMA; died September 23, 1972.

MILLER, NEILL D., Ft. Pierce; born October 16, 1925; University of Louisville, 1948; died November 2, 1986.

MOORE, MAURICE, Casselberry; born October 20, 1900; Queen's University, Ontario; member AMA; died May 23, 1985.

MURPHY, LORRAINE, Mt. Dora; born August 28, 1930; University of Miami, 1961; member AMA; died June 9, 1986.

NIX, HAROLD G., Tampa; born August 28, 1909; University of Virginia, 1933; member AMA; died November 15, 1986.

PARYANI, BHOJRAR T., Jacksonville; born February 24, 1924; Dow Medical College, Pakistan, 1946; died March 26, 1986.

PEJOVIC, ILIJA, West Palm Beach; born May 25, 1919; University of Belgrade, Yugoslavia; died March 6, 1986.

PINO, MARIO J., Miami; born April 7, 1910; Havana University, 1938; died September 1986.

RIGG, JOHN F., North Palm Beach; born September 15, 1893; Indiana University, 1920; member AMA; died November 15, 1986.

SALA, FERNANDO, Miami; born April 9, 1906; University of Havana, 1934; died June, 1986.

SAN MARTIN, EMILIO, Pompano Beach; born January 25, 1925; University of Havana, 1951; died May 20, 1986.

SANTAYANA, RAFAEL A., St. Petersburg; born October 16, 1911; University of Havana, 1940; member AMA; died July 7, 1986.

SCHOSHEIM, ARNOLD M., West Palm Beach; born January 29, 1922; Middlesex University, Massachusetts, 1945; died October 14, 1986.

SHEPPERD, LEWIS A., Miami; born December 4, 1915; University of South Carolina, 1940; member AMA; died May 25, 1986.

SMITH, LYNWOOD B., Brooksville; born April 28, 1916; Johns Hopkins University, 1942; member AMA.

STRICKLAND, EDMOND T., Ocala; born April 21, 1934; Medical College of Georgia, 1959; died July 10, 1986.

STUART, JACK, West Palm Beach; born December 3, 1917; Cornell, 1951; died August 29, 1986.

TAYLOR, JR., JOSEPH W., ampa; born September 20, 1919; Harvard, 1944; member AMA; died July 18, 1986.

THOMSON, ROBERT V., Miami; born August 2, 1909; University of Iowa, 1942; died November 23, 1986.

TUCKER, JOSEPH B., Vero Beach; born August 31, 1936; University of Missouri, 1962; died August 2, 1986.

TUREK, SAMUEL, Miami; born August 30, 1911; Northwestern University, 1935; member AMA; died September 7, 1986.

VACHA, VICTORIA B., Orange City; born June 6, 1909; Loyola, 1947; member AMA; died October 4, 1986.

VOLLENWEIDER, JUAN C., Fort Walton Beach; born March 17, 1933; University of Cincinnati, 1960; died September 27, 1986.

WEAVER, JAMES M., Ft. Lauderdale; January 4, 1918; Emory University, 1943; member AMA; died August 18, 1986.

ZARDON, RAMON, Miami; born August 7, 1928; Havana University of Havana, 1955; died July 16, 1986.

ZIMMERMAN, PAUL A., Miami; born November 17, 1910; Vanderbilt University, 1937; member AMA; died July 30, 1986.

ZUCKER, I. RICHARD, Hallandale, born June 13, 1913; University of Michigan, 1938; died October 2, 1986.

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Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

MARCH

Internal Medicine 1987, March 1-6, Bal Harbour, Division of CME (D23-3), University of Miami, (305) 547-6716.

Psychiatry for the Non-Psychiatric Physician, March 2-6, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

Annual Medical Update Course, March 2-13, Holy Cross Hospital, Ft. Lauderdale. Contact: David E. Eifrig, M.D., (919) 966-5296.

Three-Day Diabetes Management Course, March 3-5, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

Infectious Diseases and Antibiotic Therapy '87, March 4-7, Hotel Royal Plaza, Orlando. For more information: Barry E. Seiger, M.D., (305) 841-5144.

Eighth Annual Intensive Care for Neurological Trauma and Disease, March 4-8, Contemporary Resort, Orlando. For more information: University of Miami, Gloria Allington, Division of CME, Univ. of Miami, (305) 547-6716.

Eleventh Annual Midwinter Seminar in OB/GYN, March 5-7, Don CeSar Hotel,St. Petersburg Beach. Contact: University of South Florida, (813) 974-2088.

The Heart and Brain Clinical Inter-Relationships, March 9-11, Good Samaritan Hospital, West Palm Beach. Contact: Barbara L. Breznen, (305) 650-6236.

Tenth Annual Problems in Rheumatology, March 11-14, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For more information: Helen Barnwell (813) 974-2681.

Clinical Management of the Elderly Patient, March 12-14, Palace Hotel, Lake Buena Vista. Contact: Health and Education Council, (301) 686-3610.

Advances and Improvements in Hernia Surgery, March 12-14, Hyatt Regency, Miami. Contact: Arthur I. Gilbert, M.D., 6614 Miami Lakes Drive East, Miami Lakes 33014, (305) 687-1367.

Eighteenth Annual Topics in Internal Medicine, March 12-14, Hilton Hotel, Gainesville. Contact: Craig S. Kitchens, M.D., (904) 375-6247.

Cancer Conference Daytona Beach, March 13-14, Halifax Hospital Medical Center, Daytona Beach. For more information contact: Terry Bloom, M.D., (904) 254-4210.

Critical Care Dialogues, March 14, Rusty Pelican Restaurant, Tampa. Contact: David Solomon, M.D., (813) 972-7543.

Advances in Spinal Surgery VII, March 17-22, Bal Harbour. For more info: University of Miami, Division of CME (D23-3), (305) 547-6716.

Trauma Tactics Symposium, March 20-21, Good Samaritan Hospital, West Palm Beach. For more info: Barbara L. Breznen, (305) 650-6236.

Case Study Approach to Risk Management and Malpractice, March 20 and March 28, Miami, Orlando. Contact: Gloria Allington, (305) 547-6716.

Vascular Surgery, 1987, March 22-24, Hilton Hotel, Good Samaritan Hospital. Contact: Barbara L. Breznen, (305) 650-6236.

Diagnosing Dermatology and Infectious Diseases in Pediatrics, March 23-25, Good Samaritan Hospital, West Palm Beach. For more information: Barbara L. Breznen, (305) 650-6236.

Ninth Annual Family Practice Review, March 23-27, Holiday Inn Surfside, Clearwater Beach. Contact: Charles Aucremann, M.D., 701 Sixth St. South, St. Petersburg 33701, (813) 983-6156.

Internal Medicine Update '87, March 23-28, Orlando Peabody, Orlando. Contact: Barry E. Sieger, M.D., (305) 841-5144.

APRIL

Issues and Advances in Pediatrics 1987, April 2-4, Sheraton Sand Key Resort, Clearwater Beach. Contact: L.A. Barness, M.D., (813) 974-4214.

Coronary Heart Disease, April 3-4, Marco Beach Resort, Marco Island. Contact: Deborah Wilderson, (303) 798-9682.

Pediatric Oriented ACLS Provider Course, April 3-5, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Practical Aspects of Newer Cardiovascular and Renal Therapies, April 5-8, Orlando. Contact: Division of CME (D23-3), University of Miami, (305) 547-6716.

Interdisciplinary Rape Science Institute, April 5-10, Miami. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Sports Medicine and Office Orthopedics, April 6-10, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

Tutorial Course in Acute Cardiac Care for the Practicing Physician, April 6-11, University of Miami, Division of CME (D23-3), University of Miami, (305) 547-6716.

Issues in Prenatal Care — 1987, April 10-11, Indigo Lakes, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Blvd., Daytona Beach 32014, (904) 252-4701.

Advances in Magnetic Resonance Imaging, April 13-16, Palace Hotel, Orlando. Contact: Charleen Krissman, (813) 974-2538.

Coping With Stress and Anxiety, April 13-17, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

1987 Update on Diseases and Imaging of the Spine, April 17-18, Palace Hotel, Orlando. Contact: Charleen Krissman, (813) 974-2538.

Outpatient Gynecology, April 20-24, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

Second Congress on Sports Injuries for the Primary Care Physician, April 23-25, Village of Grenclefe, Grenelife, FL. Contact: Brian C. Halpern, M.D., (904) 324-6661.

1987 Radiation Therapy Clinical Research Seminar, April 23-25, University Centre Hotel, Gainesville. Contact: Timothy A. Brant, M.D., Radiation Therapy Division, University of Florida, JHMHC J-385, Gainesville 32610, (904) 395-0287.

Geriatrics — Anesthesia Risks, April 24-26, Holiday Inn, Pensacola Beach. Contact: Warren W. Sears, M.D., (904) 434-4718.

Miami Comprehensive Review Course in Anesthesiology, April 25-May 2, Key Biscayne. For more information: University of Miami, Division of CME (D23-3), (305) 547-6716.

MAY

Chest Pain 1987, May 1-2, New World Landing, Pensacola. Contact: (904) 434-1093.

Radiology Review Course, May 3-8, Sheraton Bal Harbour, Miami. Contact: Lucy R. Kelley, (305) 674-2681.

Comprehensive Review and Update in Emergency Medicine, May 4-8, Hyatt Regency Westshore, Tampa. Contact: Eilleen Weimerskirch, M.D., (214) 550-0911.

Five-day Management of Diabetes Mellitus, May 11-15, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

Pediatrics for the Practitoner — Update on Learning Disabilities, May 15, Bay Harbor Inn, Tampa. For more information: Herbert Pomerance, M.D., 813-974-4214.

Practical Applications in Internal and Emergency Medicine, May 25-29, Marco Island Resort, Marco Island. Contact: Albert J. Finestone, M.D., (215) 221-4787.

Master Approach to Cardiovascular Problems, May 30-June 1, Contemporary Hotel, Lake Buena Vista. Contact: Agustin Castellanos, M.D., (305) 549-7124.

JUNE

Family Practice '87, June 8-11, Hilton Hotel, Orlando. Contact: Thomas Stewart, M.D., (912) 452-2213.

Diagnosis and Management of Respiratory Disease, June 19-21, Dutch American Hotel, Orlando. Contact: Deborah Wilderson, (303) 798-9682.

JULY

1987 Clinical Conference on Pre-Hospital Emergency Care, July 9-12, Orlando Hyatt, Kissimmee. Contact: Registrar, (305) 628-4800.

Heart Healthy Recipe

STUFFED PEPPERS

4 tablespoons corn oil
2 onions, sliced
2 cloves garlic
1 zucchini, diced
4 tomatoes
2 cups cooked brown rice
½ cup cheddar cheese, grated
4 large green peppers, seeded
2 cups tomato juice

Heat oil in large skillet over medium heat, and sauté onions, garlic, zucchini and tomatoes. Combine rice and cheese and add to the above mixture.

Stuff peppers with the vegetable mixture and replace pepper top. Pour tomato juice into the bottom of a casserole dish. Place peppers in casserole.

Bake for ½ hour at 375°F.
Yield: 4 servings
Approx. cal/serv.: 325

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DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

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EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

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WANTED: SPECIALISTS in all surgical and medical fields for evaluations of medical records. Excellent compensation. Send your C.V. to Miss Eva Wagda. 1040 N.W. 6th St., Boca Raton, 33432 or phone 1-305-394-3311.

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WANTED: GASTROENTEROLOGIST, endoscopist. Join medical group. Guaranteed salary with percentage of gross professional fees. Start immediately. C-1372, P.O. Box 2411, Jacksonville, FL 32203.

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INTERNIST WANTED: For association with four internists. Southeast coast of Florida. Board Qualified. Salary $50,000, plus percentage. Early partnership assured. Reply: P.O. Box 768, Lake Worth, Florida 33460.

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UROLOGIST, Central Florida area. Post-graduate fellowship or specially trained preferred. Board Elective/Certified. Association leading to partnership. Very active practice. C-1379, P.O. Box 2411, Jacksonville, FL 32203.

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PSYCHIATRIST: Full-time position open for Board Certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient and limited inpatient oncall. Florida license needed. Reply to George A. Michas, M.D., Psychiatrist, 235 Carmel Drive, Ft. Walton Beach, Floirda 32548.

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RADIOLOGIST: Board Certified, Florida license, seeking to relocate. University trained, extensive experience in all phases of radiology including administration and teaching. C-1374, P.O. Box 2411, Jacksonville, 32203.

UROLOGIST — American, university-trained, Board eligible, experienced with prosthetics, laser, endourology, ESWL, looking for practice opportunity in Florida. Available February 1987. C-1371, P.O. Box 2411, Jacksonville, 32203.

PRIME OFFICE SPACE available for purchase or sharing. Located between two acute care hospitals. W. Port Charlotte, FL. Call Wes Clark at (813) 772-9099.

INTERNIST, 46, Board Certified, Mayo Clinic trained, bilingual English-Spanish, experienced in primary-consultative care, ICU-CCU, FFS-Prepaid practice, seeks position in Florida. Sim Gesundheit, M.D., 1835 Major Drive, Minneapolis, MN 55422.

EXPERIENCED BC RADIOLOGIST, Florida license, locum tenens or part-time work only. Radiology; Nuclear Medicine; CT; Ultrasound; Mammography. Curriculum Vitae and references on request. C-1371, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE PHYSICIAN, Florida licensed, with 15 years experience in primary care seeks office based position in Palm Beaches. C-1376, P.O. Box 2411, Jacksonville, FL 32203.

UNIVERSITY TRAINED PEDIATRICIAN with flexible interest and background in general medicine and emergency medicine, wants to relocate in Florida. Available April, 1987. Contact: Dr. Vaswani, 6535 Premier Drive, Apt. G-8, Nashville, Tennessee 37209.

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Practices Available

MEDICAL PRACTICE FOR SALE: Retiring. Large established general practice for sale. Medical Doctor has practiced general surgery and family medicine in same community for 37 years. Fully equipped medical office with trained staff, in Flagler County. Fast growing area. Close to hospital and nursing home. Ideal opportunity for solo practitioner or satellite office for multi-specialty group. Good will for sale — office for lease. Will introduce to patients if you would like. Available immediately. Inquiries 904-437-2481.

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RETIRING BOARD CERTIFIED OB/GYN selling or leasing completely equipped office. Capacity for 2 or more Ob-Gyns. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone 305-667-3677.

ST. PETERSBURG — Adult and geriatric practice available for qualified family practitioner or internist. Fully equipped, staffed, and operational. All expenses paid except insurance and transportation. No investment needed. Dr. Wilde, (813) 898-0519 (evenings).

LIFE STYLE CHANGE? Island practice, Fla. west coast. Office only, internal medicine. Four days summer, five days season. Gross $125,000. Cost $50,000 including equipped office available Summer/Fall '87. C-1375, P.O. Box 2411, Jacksonville, FL 32203.

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FAMILY PRACTICE FOR SALE: High volume family practice, west coast of Florida, south of Tampa/St. Pete. Suitable for two physicians. Eight exam rooms, all fully equipped, lab, x-ray, computerized business office. Expanding area, two local hospitals. For further information, contact Box C-1361, P.O. Box 2411, Jacksonville, FL 32203.

Real Estate

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FOR LEASE: Office space available in multi-specialty medical complex. From 943 sq. ft. to 1600 sq. ft. Central location close to hospitals. Rapidly growing area, in Brevard County. C-1367, P.O. Box 2411, Jacksonville, FL 32203.

FLORIDA, W. PALM BEACH: Office condo, suitable for 2 doctors, near 3 hospitals; 2 consultation rooms, 2 examination rooms, x-ray room and equipment included. I Stern, Merrill Lynch Realty, 305-655-2424 or 659-2983.

SPACE AVAILABLE — 1500 sq. ft. finished medical/dental office on U.S. Highway No. 1, North Palm Beach. Terms negotiable. Call (205) 626-8300 for more information.

ORLANDO: nearly new bldg., excellent location off Interstate, 4 blocks Florida Hospital. Two or four exam rooms, 1500 sq. ft., lease or purchase. (305) 898-3641.

STRATEGICALLY LOCATED OFFICE CONDO for sale. Professional medical building between two acute care hospitals. Newly constructed and fully occupied building in Port Charlotte, FL. Call Wes Clark at 813-772-9099.

ORLANDO: 2272 sq. ft. medical building for sale or lease. Practice and equipment also available. Located in rapidly growing area. For additional information contact L. Besse or M. Ballard, Merrill Lynch Realty (305) 841-6060.

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LONG TERM FINANCING for starting/purchasing practices, diagnostic centers, equipment, office condos, buildings. $25,000 to $1,000,000. Western Financial, 1380 Miami Gardens Drive, N. Miami Beach, FL 33179, (305) 949-5900.

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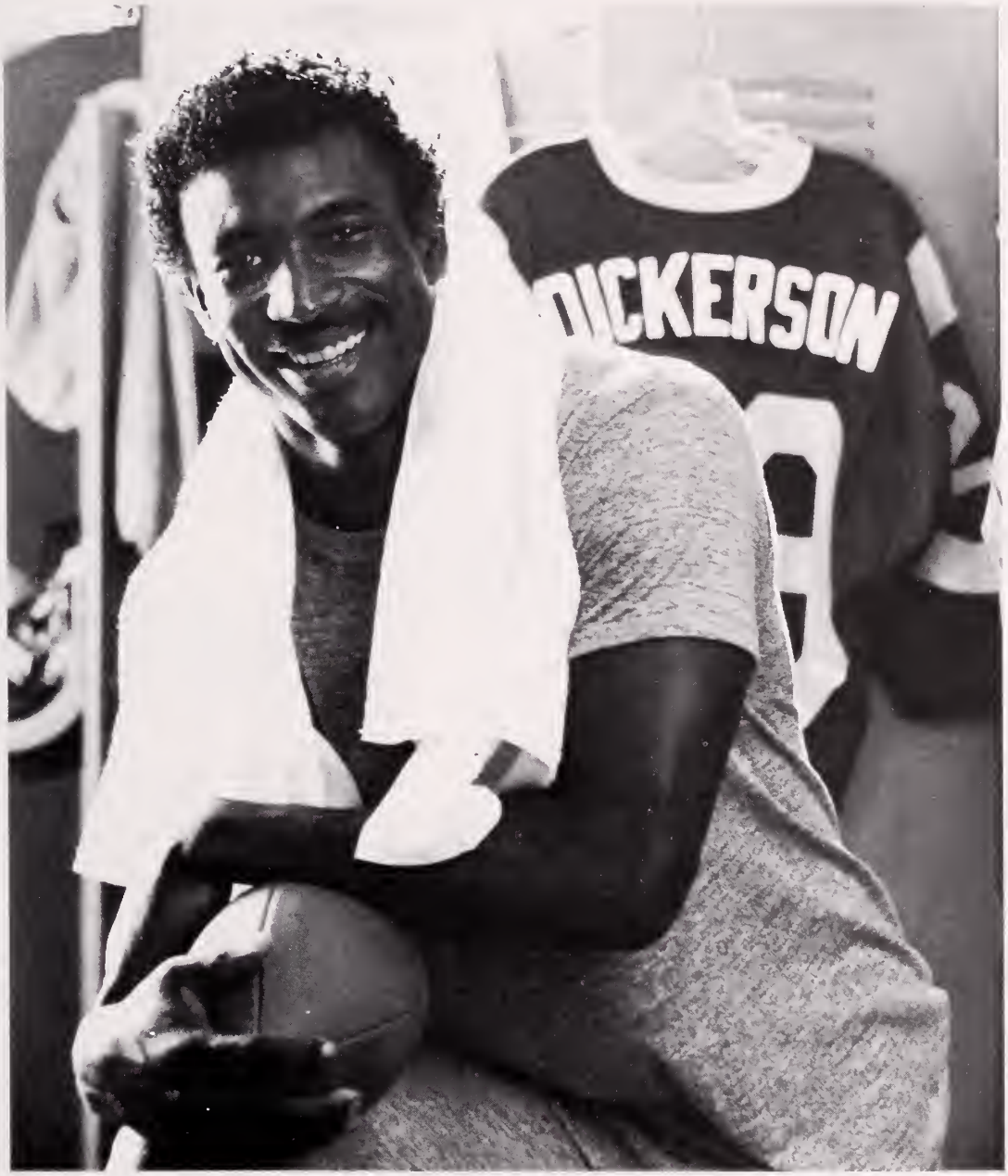
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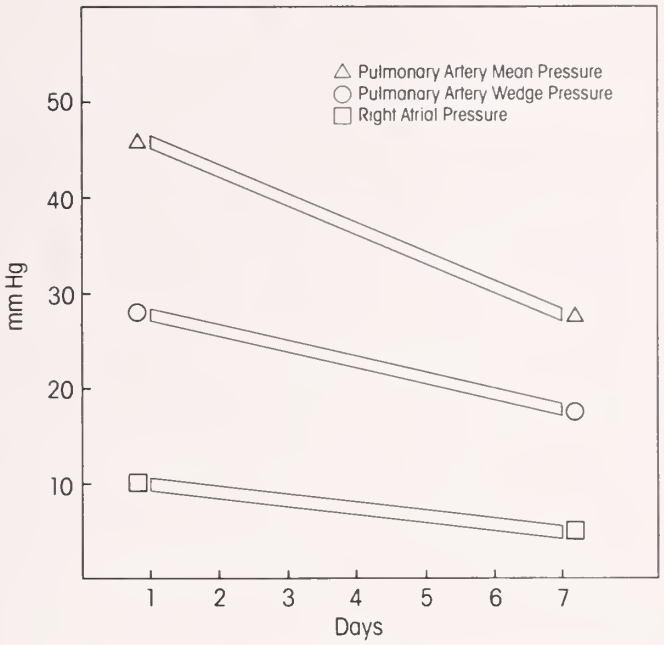
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and 10-ml vials (0.25 mg/ml)

REDUCES FLUID OVERLOAD and eases the burden on the failing heart



Significantly improves hemodynamics



Ten patients with CHF showed marked hemodynamic improvement after seven days of BUMEX® (bumetanide/Roche) (mean values ± SE). Adapted from Olesen, *et al* [1]

References: **1**. Olesen KH, *et al*: *Postgrad Med J 51* (Suppl 6): 54-63, 1975 **2**. Handler B, Dhingra RC, Rasen KM: *J Clin Pharmacol 21*: 706-711, Nov-Dec 1981 **3**. Brater DC, *et al*: *Clin Pharmacol Ther 34*: 207-213, Aug 1983 **4**. Brater DC, Fox WR, Chennavasin P: *J Clin Pharmacol 21*: 599-603, Nov-Dec 1981. **5**. Davies DL, *et al*: *Clin Pharmacol Ther 15*: 141-155, Feb 1974

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bumetanide/Roche
0.5-mg, 1-mg and 2-mg scored tablets,
2-ml ampuls, 2-ml, 4-ml and
10-ml vials (0.25 mg/ml)

BUMEX® (bumetanide/Roche)
Before prescribing, please consult complete product information, a summary of which follows:

WARNING: Bumex (bumetanide/Roche) is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dosage schedule have to be adjusted to the individual patient's needs. (See under DOSAGE AND ADMINISTRATION in complete product information.)

INDICATIONS AND USAGE: Edema associated with congestive heart failure, hepatic and renal disease, including the nephrotic syndrome
Almost equal diuretic response occurs after oral and parenteral administration of Bumex. If impaired gastrointestinal absorption is suspected or oral administration is not practical, Bumex should be given by the intramuscular or intravenous route
Successful treatment with Bumex following instances of allergic reactions to furosemide suggests a lack of cross-sensitivity
CONTRAINDICATIONS: Anuria. Hypersensitivity and in patients in hepatic coma or in states of severe electrolyte depletion. Although Bumex can be used to induce diuresis in renal insufficiency, any marked increase in blood urea nitrogen or creatinine, or the development of oliguria during therapy of patients with progressive renal disease, is an indication for discontinuation of treatment
WARNINGS: Dose should be adjusted to patient's needs. Excessive doses or too frequent administration can lead to profound water loss, electrolyte depletion, dehydration, reduction in blood volume and circulatory collapse with the possibility of vascular thrombosis and embolism, particularly in elderly patients.
Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risks to the patients
In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients
In cats, dogs and guinea pigs, Bumex has been shown to produce ototoxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ototoxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially at high doses
Patients allergic to sulfonamides may show hypersensitivity to Bumex
PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets
Hyperuricemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion
Possibility of effect on glucose metabolism exists. Periodic determinations of blood sugar should be done, particularly in patients with diabetes or suspected latent diabetes.
Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions.
Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions
Drugs with nephrotoxic potential and bumetanide should not be administered simultaneously. Since lithium reduces renal clearance and adds a high risk of lithium toxicity, it should not be given with diuretics
Probenecid should not be administered concurrently with Bumex
Concurrent therapy with indomethacin not recommended
Bumex may potentiate the effects of antihypertensive drugs, necessitating reduction in dosage
Interaction studies in humans have shown no effect on digoxin blood levels
Interaction studies in humans have shown Bumex to have no effect on warfarin metabolism or on plasma prothrombin activity.
Pregnancy: Bumex should be given to a pregnant woman only if the potential benefit justifies the potential risk to the fetus.
Bumetanide may be excreted in breast milk
Pediatric Use: Safety and effectiveness below age 18 not established
ADVERSE REACTIONS: Muscle cramps, dizziness, hypotension, headache and nausea, and encephalopathy (in patients with preexisting liver disease)
Less frequent clinical adverse reactions are weakness, impaired hearing, rash, pruritus, hives, electrocardiogram changes, abdominal pain, arthritic pain, musculoskeletal pain and vomiting
Other clinical adverse reactions are vertigo, chest pain, ear discomfort, fatigue, dehydration, sweating, hyperventilation, dry mouth, upset stomach, renal failure, asterixis, itching, nipple tenderness, diarrhea, premature ejaculation and difficulty maintaining an erection.
Laboratory abnormalities reported are hyperuricemia, azotemia, hyperglycemia, increased serum creatinine, hypochloremia, hypokalemia, hyponatremia, and variations in CO_2 content, bicarbonate, phosphorus and calcium. Although manifestations of the pharmacologic action of Bumex, these conditions may become more pronounced by intensive therapy
Diuresis induced by Bumex may also rarely be accompanied by changes in LDH, total serum bilirubin, serum proteins, SGOT, SGPT, alkaline phosphatase, cholesterol, creatinine clearance, deviations in hemoglobin, prothrombin time, hematocrit, platelet counts and differential counts
Increases in urinary glucose and urinary protein have also been seen.
DOSAGE AND ADMINISTRATION:
Oral Administration: The usual total daily dosage is 0.5 to 2.0 mg and in most patients is given as a single dose
Parenteral Administration: Administer to patients (IV or IM) with GI absorption problem or who cannot take oral. The usual initial dose is 0.5 to 1 mg given over 1 to 2 minutes. If insufficient response, a second or third dose may be given at 2 to 3 hour intervals up to a maximum of 10 mg a day
HOW SUPPLIED: *Tablets*, 0.5 mg (light green), 1 mg (yellow) and 2 mg (peach), bottles of 100 and 500; Prescriptiban Paks of 30; Tel-E-Dose® cartons of 100. Imprint on tablets: 0.5 mg—ROCHE BUMEX 0.5, 1 mg—ROCHE BUMEX 1, 2 mg—ROCHE BUMEX 2
Ampuls, 2 ml, 0.25 mg/ml, boxes of ten
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OVERLOAD

Reduce fluid volume and improve hemodynamics in CHF

Edema due to congestive heart failure often demands highly effective diuresis to reduce the fluid load on the failing heart. Bumex® (bumetanide/Roche) is the next generation in loop diuretic therapy for three powerful reasons. It moves out an unsurpassed volume of fluid and sodium, resulting in significant reductions in edema and right atrial and pulmonary artery wedge pressures.[1,2] It's almost completely absorbed through the GI tract, so it's easy to titrate.[3] And Bumex completes high-volume diuresis fast—within four hours at usual doses.[4,5] Your patients spend less time in diuresis, more time in normal activities.

Bumex has a good safety profile; however, as with all loop diuretics, Bumex, if given in excessive amounts, can lead to profound diuresis with water and electrolyte depletion, including hypokalemia. Serum electrolytes should be monitored periodically, especially in patients on low salt diets or those treated for prolonged periods or on high doses.



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First line loop diuretic therapy

Please see references and summary of product information on preceding page.

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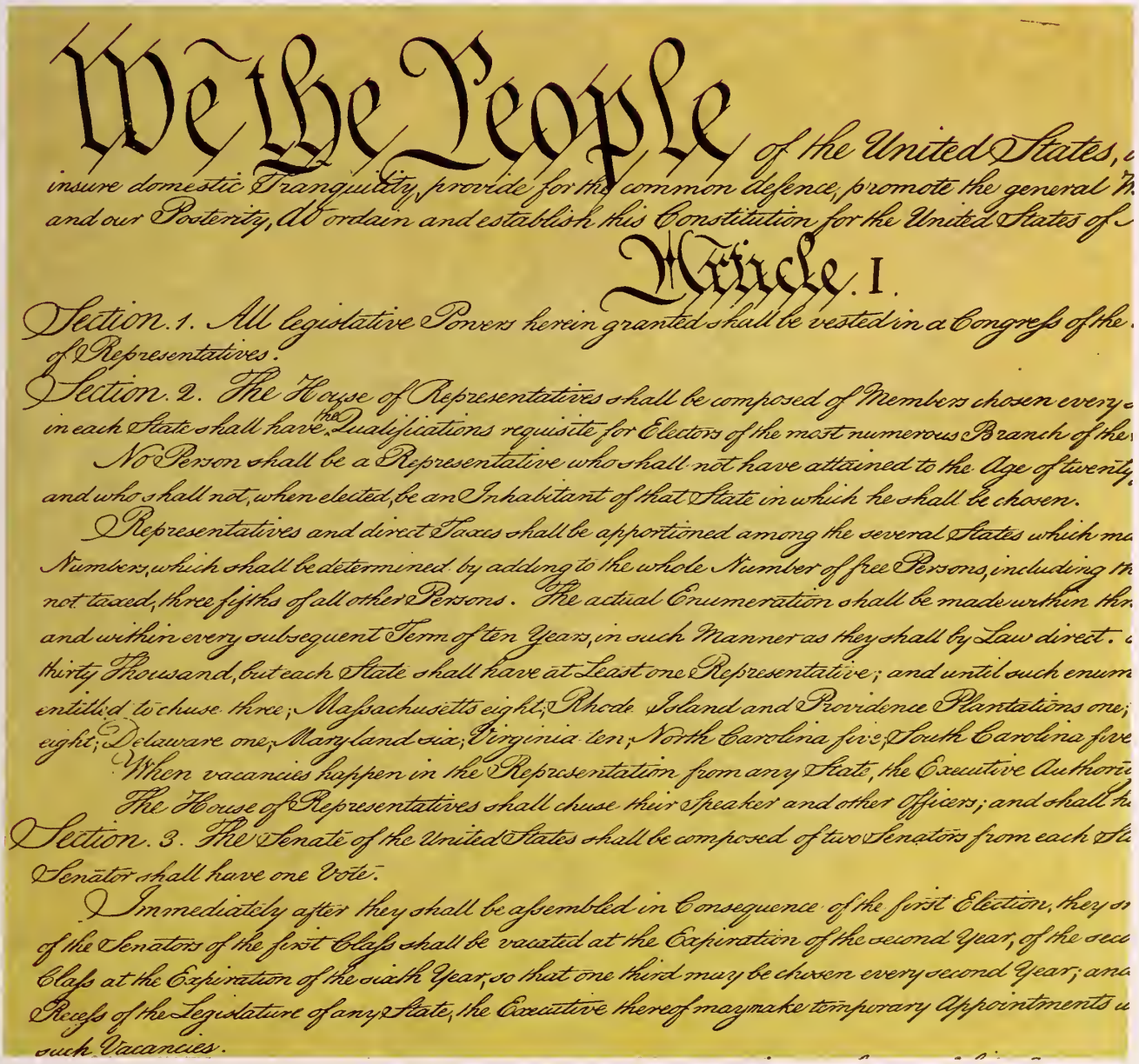
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We the People of the United States, [illegible] insure domestic Tranquility, provide for the common defence, promote the general [illegible] and our Posterity, do ordain and establish this Constitution for the United States of [illegible]

Article. I.

Section. 1. All legislative Powers herein granted shall be vested in a Congress of the [illegible] of Representatives.

Section. 2. The House of Representatives shall be composed of Members chosen every [illegible] in each State shall have the Qualifications requisite for Electors of the most numerous Branch of the [illegible]

No Person shall be a Representative who shall not have attained to the Age of twenty [illegible] and who shall not, when elected, be an Inhabitant of that State in which he shall be chosen.

Representatives and direct Taxes shall be apportioned among the several States which may [illegible] Numbers, which shall be determined by adding to the whole Number of free Persons, including those [illegible] not taxed, three fifths of all other Persons. The actual Enumeration shall be made within three [illegible] and within every subsequent Term of ten Years, in such Manner as they shall by Law direct. The [illegible] thirty Thousand, but each State shall have at Least one Representative; and until such enumeration [illegible] entitled to chuse three; Massachusetts eight; Rhode Island and Providence Plantations one; [illegible] eight; Delaware one; Maryland six; Virginia ten; North Carolina five; South Carolina five; and [illegible]

When vacancies happen in the Representation from any State, the Executive Authority [illegible]

The House of Representatives shall chuse their Speaker and other Officers; and shall have [illegible]

Section. 3. The Senate of the United States shall be composed of two Senators from each State, [illegible] Senator shall have one Vote.

Immediately after they shall be assembled in Consequence of the first Election, they shall [illegible] of the Senators of the first Class shall be vacated at the Expiration of the second Year, of the second [illegible] Class at the Expiration of the sixth Year, so that one third may be chosen every second Year; and if [illegible] Recess of the Legislature of any State, the Executive thereof may make temporary Appointments until [illegible] such Vacancies.

Medicine and the 1987 Legislative Session



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	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

- Vicodin offers: less nausea, less sedation, less constipation.

...and longer lasting pain relief– up to 6 hours.

- Vicodin contains hydrocodone not codeine. In one study, 10 mg. of hydrocodone alone was shown to be as effective as 60 mg. of codeine.[1]
- In a double-blind study, Vicodin (2 tablets), provided longer lasting pain relief than 60 mg. of codeine.[2]

Plus...

- Vicodin offers the convenience of CIII prescribing.
- Dosage flexibility–1 tablet every 6 hours or 2 tablets every 6 hours (up to 8 tablets in 24 hours).

Vicodin®

hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.

The original hydrocodone analgesic.

Specify "Dispense as written" for the original hydrocodone analgesic.

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur, they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. S685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.



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vicodin®

hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.

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CONFIRMED BY CLINICAL EVIDENCE

ZANTAC® 150 h.s.

ranitidine HCl/Glaxo 150 mg tablets

EFFECTIVE MAINTENANCE THERAPY

for healed duodenal ulcer patients

CONFIRMED

In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

Percent of patients with observed duodenal ulcer recurrence

		0-4 months	0-8 months	0-12 months	No. patients
USA[1]	ranitidine 150 mg h.s.	9%	14%*	16%†	60
	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia[2]	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

*p=0.02
†p=0.01
‡p≤0.004
%=life-table estimates
All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a

low incidence of side effects[3]

Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the **ADVERSE REACTIONS** section in the Brief Summary.

No significant interference with the hepatic cytochrome

P-450 enzyme system at recommended doses

ZANTAC 150 mg has no significant drug interactions with theophylline, phenytoin, or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications that decrease gastric acidity are administered.

Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime
for maintenance

See next page for references and
Brief Summary of Product Information.

Glaxo / ROCHE®

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Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime for maintenance therapy in healed duodenal ulcer patients

References:

1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.
3. Data available on request, Glaxo Inc.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

The following is a brief summary only. Before prescribing, see complete prescribing information in ZANTAC® product labeling.

INDICATIONS AND USAGE: ZANTAC® is indicated in:

1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer, active, benign gastric ulcer, hypersecretory states, and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to ZANTAC® administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

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This month's cover of *The Journal*, featuring the Constitution of the United States, depicts the theme of this month's "Medical Economics" Section. Two hundred years ago at the Philadelphia Convention between May and September 1787, the Constitution was drafted, creating our federal structure of state and national governments.

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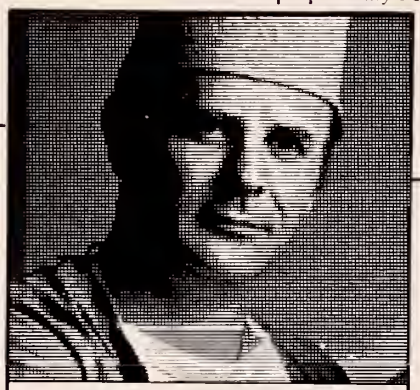
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A look at the future? Or is it now?



As I lay in my extended care facility bed in this year 2047 looking back on life, it seemed a bit hazy, but certain salient points came to mind. Just three weeks before in four and three-quarters hours' time, I had completed the 52nd running of the New York City marathon at the age of 116 years. Not a particularly remarkable feat when it was considered that there were 45 other centurians who had done the same thing, some of whom were older than myself. The fitness craze of the 70's and 80's waned a bit at the turn of the century, but the new millennium had caused many challenges. People frustrated by the problems of the AIDS pandemic and the amorality of permissive society bloated with its own excesses tried to flee back, to exercise in a spirituality undreamed of in the mid-1900's. This was a vanity-preserving mechanism, and a sort of flight into recognition, not of a single God, but of numerous deities, including Allah, Buddhas, and even some of the so-called anti-Christs.

My great-grandson had trekked the 26 plus miles with me; a rising high school track star, he felt he could go the distance with his "good old buddy!"

Go the distance. An interesting reflection. Absolutes were so imponderable now; more so than I suspected. We finally had a few solutions to some of the problems that were beginning to be handled and coming within grasp after three decades of fussing and fuming. Then, all of a sudden, the problems that seemed so insurmountable and wretched; that wrenched us apart as a society, were really miniscule. AIDS was causing 1-2 million deaths worldwide a year for 20 years, and then even though the virus was known and a vaccine developed to prevent it, nothing really slowed the problem down until people suddenly turned back to God because of fear. Fear for their lives and fear of institutions that claim to be the solution to all sorts of problems; but they really were empty promises and a house of cards.

I remember well the so-called crisis in health care. So complex. So many tangents and factors interdigitating one upon another; but suddenly, people solved it themselves. They realized the interdependence of one upon another. Professional liability was solved by contract law, but peoples rights associated with value meant dollars, and the dollar was God. Suddenly, these false gods meant nothing because death stalked everywhere. Then people realized their need for support of one upon another and dependence upon families and clans. People scoffed at a false idol. They realized that their needs for support of one upon another. People scoffed at the false idol of tort law and materialism and realized that they could neither digest ill-gotten gain which in reality destroyed not only themselves, but all of their neighbors and their children's children. The elderly were the indirect leaders. They had lived through a legal nightmare, more oftenly and effectively termed in a very derogatory term, the "holocaust."

Federal intervention eventually became collectivism and was but a feeble attempt, in retrospect, to offer solutions. These solutions ended up with a nationalized type of governmental care for medical service as well as a myriad of other services and eventually caused national moral and financial bankruptcy. All of the well-intended promises turned out to be hollow. Racheting down of services and

fees lead to more and more frustration both on those who were the recipients and those of us trying to deliver care against a rising flood of imponderables. Deductibles increased and payments decreased, and those who were recipients as well as those who provided, felt the abuse, felt frustration, and were undoubtedly betrayed. Soon all of the participants in the scenario understood, perhaps as did their ancestors in a cave, that survival depended upon interdependence, reliance on family and friends, and on local, small area institutions. The elderly needing care outnumbered the struggling young trying to survive and support their small and hopefully still healthy families. These people could no longer afford to pay for an altruistic system that gave so much, demanded so much, cost so much, and had such a relative small base for the grandiose schemes administered by a benevolent federal dictatorship. Enclaves, first in Florida and Arizona and then spreading elsewhere were formed. The healthy old cared for, babysat, and helped to support the more infirm. The young and old supported and encouraged physical activities, games, sports, organized groups, and day care centers where large numbers of the more dependent people could be brought, freeing up those upon whom they were so reliant. Neighbors in churches, synagogues, and even small groups such as legion halls and clubs, turned their areas into centers that provided at first a few hours a week and then eventually 24 hour a day, 7 day a week coverage for those who could be brought in for short periods, taken out only to return a few days in the same fashion. The elderly were nurtured and helped with nutrition. Physical, mental, and emotional support, indeed, became more independent in these areas than they ever had been under the guide and care of much more expensive bureaucratic heavy, ponderable and impossible schemes.

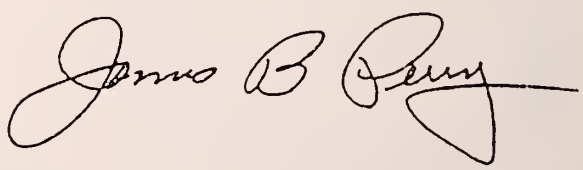
A new form of retirement community sprang up with a central core of many small shops and eating establishments, supported and crafted by those who were retired in the surrounding community. Their craftsmanship and the artistic abilities reinstituted clock- and watchmaking, leather crafts, embroidery, and every type of imaginable hobby as well as small stores that did a small amount of merchandising in groceries, fruits, meats, and sundries. These shop owners and artisans at first began to work a few hours a day, and then expanded as they and their friends bartered service or sold at their own cost to one another in a spirit of camaraderie and interdependence. It was amazing how all this extended act of lifestyle had a beneficial health effect on the retiring elderly to one and a half or even two generations beyond their expected demise.

Psychologists felt it was the desire and ability to be needed and to have direct relationships one with another, much like they did as teenagers and young businessmen decades before. Dependency on government became nonexistent and people served their only true Master, but enjoyed a vitality in life that predecessors never dreamed of. The AIDS pandemic did not touch them because real life and value existed. Monogamous relationships persisted in their group. They learned and taught skills to grandchildren and great-grandchildren. It was a rebirth of freedom and independence that the collectivist governments and the world finally had to admire and emulate. Strength, character, and a tacit disregard for all that people felt was wrong with society, at first a trickle, became a groundswell of impossibilities and succeeded.

Suddenly, as if shocked by a centrencephalic seizure, I awoke from my dream with the ringing of a phone — the sudden need to rush headlong at 3:00 a.m. to the emergency room to serve in the maelstrom of 1987. Reality?

Was my dream a vision? A prophecy? A tired body screaming to a heavenly aura and reflecting on it? Or a deja vu of a civilization past or yet to come?

In our present cacophony of ideas and problems, perhaps it was a vision of sanity or insanity yet to come. There is no black or white. There is no right or wrong that is absolute. There is an exploration for ideas and solutions. Perhaps we as people in our alien environment can arrive at a reasonable answer to our problems. We will; with God's help — and yours!



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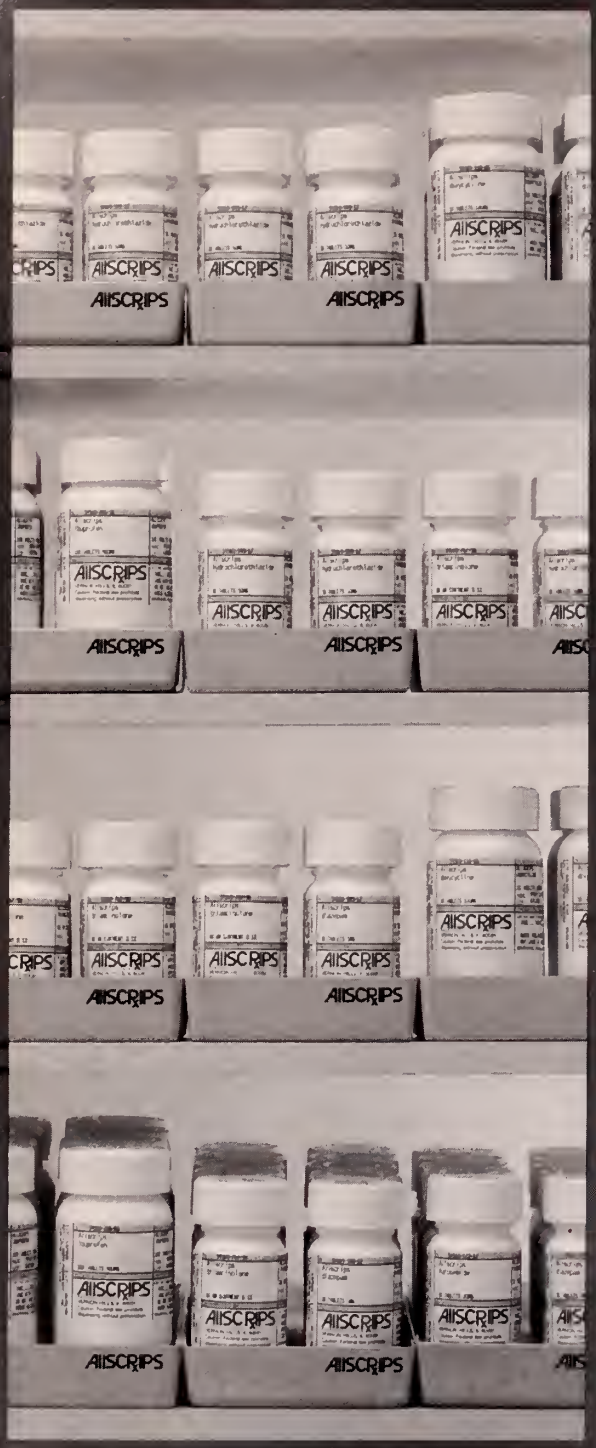
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It's time to say no to government meddling

The uneasy alliance that has marked the relationship between the medical profession and the government has become quite tenuous, and it appears more and more likely that a breaking point is but a matter of time. Physicians are seething at the idea that the government is out to control the practice of medicine with its brazen use of legislative fiat and its callous disregard of the interests of patients. Regulations from the HCFA the past few years are a classic example of governmental action that has put physicians in a corner. The growing unrest within the ranks of medicine and the increasing militancy of the AMA are a tell-tale sign that things will be different from here on.

Medicine has always prided itself as an independent profession and has successfully resisted third-party intrusion into its affairs in the past. It grudgingly accepted the law that created Medicare in 1965 only after being assured that the private practice of medicine would be preserved. AMA leaders at the time also warned that Medicare could be much, much more expensive than its sponsors had originally envisioned. And how right they were. The spiraling costs of the program inevitably led to the welter of regulations that created the PSROs, DRGs for hospitals, the PROs, the fee squeeze on physicians, the assignment program, and the potential DRGs for hospital-based physicians. The independence of the medical profession, as a consequence, has been gradually stripped away and is now but a vestige of what it used to be.

The sad plight of medicine fostered by the policies of the government raises the important question of what the precise role should be of the government in the practice of medicine. There are those who feel that the government's role should be restricted to the licensure of physicians to protect the public from unqualified and unscrupulous practitioners. This should be an ideal situation but current political realities unfortunately would not allow such a limited role. The government is heavily involved financially with Medicare, Medicaid, and a host of other programs, and it is highly unlikely that it is just going to play a token role. Most physicians, particularly those who have benefited financially from these programs, have come to accept a certain measure of governmental intervention as part of a trade-off in treating patients whose expenses for medical care are borne by the government. But the same physicians feel that the government has intruded too far, that it has overstepped its authority created by law, and that it is appropriating prerogatives that rightfully belong only to physicians. A line ought to be drawn between the administrative regulation of these government-sponsored programs and the usurpation of the practice of medicine.

Physicians have every reason to complain about the arbitrary use of regulations that are strangulating the medical profession. The overzealous pursuit of cost control at the expense of patient care has led to measures that are found only in nationalized systems of medical care. The government talks about preserving the quality of medical care but at the same time wants to impose cookbook medicine to physicians. It mandates peer review as a means to make physicians accountable for what they do but has introduced a system that is worse than the old and discredited PSROs of the 1970s. Through the HCFA, it is dangerously treading upon waters that it has no business going into.

But apart from its unwarranted incursions into the practice of medicine, the government has created a monstrous bureaucracy that is as slow, inefficient, and impersonal as most bureaucracies go. Conducting

business as simple as making telephone inquiries from Medicare intermediaries is like finding a needle in a haystack because the few lines supposedly for use by physicians are busy all the time. Appealing denials of admissions and payments for Medicare patients is even more agonizing because of the tedious red tape. The amount of money needed to sustain such a bureaucracy must be so staggering that one must wonder whether it is worth spending so much for so few tangible results.

The frightful thing about the present scenario is that the politicians who have been tinkering with our medical care system do not realize that they have created a big mess and that this inevitably will erode the foundation of the whole system. Those who feel that governmental control of medicine is good for Americans ought to go to England or Sweden or Canada and ponder if the system of medical care in these countries is what Americans really want. I think they will be in for a big disappointment when they find out that socialized medicine is not the panacea to the fiscal problems of medical care in this country.

The lesson to be learned from all these is that the business of medicine is too important a matter to be left to the care of the government and its bureaucrats. The late George Bernard Shaw would have disagreed with that, but then he did not know about Medicare or DRGs either.

R. G. Lacsamana, M.D.
Editor

The malpractice crisis, 1987

As the 1987 legislative session begins, physicians once again have the opportunity to solve the professional liability crisis that threatens to destroy the best health care system in the world. The January 1986 issue of *The Journal* (Vol. 73, No. 1, page 12) published my editorial entitled "The Liability Crisis: 1986 and Beyond," with ideas that could be implemented to solve the crisis. Since the passage of tort reform legislation during the 1986 legislative session, I have developed other recommendations that could help to solve the problem. Despite the fact that I am not an attorney and, therefore, do not know if all my suggestions are legally possible, they seem to make sense. Perhaps my ideas will stimulate further thought and debate and ultimately become part of a long-term solution.

Since the demise of the mediation panels, too much emphasis has been placed on trying to change tort law after a case has gone to court. For example, FMA and other groups have spent much time and many dollars trying to cap payments for general damages, and limit attorney's fees. While these may be laudable goals and would probably help our cause, they are almost unnecessary if we can prevent cases from getting into court in the first place (i.e. if a case never makes it to court, who cares if general damage awards are unlimited). My 1987 recommendations will focus on making it more difficult to get a case into court and through the system.

- Last year I recommended that FMA compile a list of all lawsuits filed in Florida, the name of the plaintiff's attorney, and the cases' final disposition. Together with the Department of Insurance, FMA could collect data on which attorneys are filing malpractice suits and their batting averages. Armed with this data we could confront the public and the bar with the information that Perry Mason, attorney-at-law, filed 15 malpractice suits last year, lost 12 and dropped three. It is time we urge the legislature to pass a law that requires mandatory review by the bar with appropriate discipline of any lawyer who loses or drops, say, three cases in two years. After all, the legislature did that to us last year. I am sure the attorneys will not object, considering they are in favor of physicians policing themselves. How often have we heard, "If the doctors would police themselves and get rid of the bad apples, there would not be any malpractice." Likewise if the bar policed itself, there would not be as many frivolous lawsuits and as many untrained lawyers trying to make a big hit in the court room.

- The present law states that before a suit can be filed , the plaintiff must serve notice of intent to sue and give the defendant 90 days notice prior to filing the suit. The plaintiff's attorney must also affirm that he has sufficient cause with which to bring suit, usually by an affidavit from someone stating that the physician was negligent. I believe that this section of the law presents real possibilities for meaningful change in the system. I suggest that the law be amended to require that the plaintiff must have sworn opinion from a physician in the same specialty practicing in the same clinical setting (clinical practice or academia) as the defendant physician. The present law allows the plaintiff to get a two page written opinion from a resource service that will say practically anything the plaintiff wants. Requiring a physician's opinion that the defendant was negligent may weed out some frivolous suits.

- Following the 90 day "settlement period" and before a suit may be filed, both sides must attend a hearing before a judge, at which time the plaintiff may present his expert's opinion and the defendant may present his side. As part of this process, each county should be required to establish a physician-attorney review panel with members from the county medical society and the county bar that would be required to review the case. The panel's opinion would be heard

by the judge at this pre-suit hearing. If at this point, the judge believed that the suit might be justified, then the case would be set for trial. If not, the judge would grant summary judgement and the suit would be dismissed.

For those suits that do go to trial, the following changes must be enacted in order for our medical care system to remain alive.

- Structured payment of damages must be mandated and paid out as the costs for future care are incurred. All payments for care would stop once the claimant dies, except for future wages. It is totally insane for families to inherit millions of dollars that were meant to pay for 50 years of care when the patient dies two years after winning the suit.

- Attorneys should be paid on a decreasing fee system so that they receive proportionately less as the award increases.

- All physicians must carry basic malpractice insurance at the state mandated level of $250,000/$750,000 for those physicians with hospital privileges, but this requirement must be coupled with the elimination of joint and several liability. If all physicians carried the same amount of insurance, there would be no "deep pocket." For those of you who say, "But, what about my assets if the award is greater than my coverage?" read on.

- If we assume that it is the consumer of medical services (i.e. the public) who wants a financial guarantee that if he or a member of his family is injured he will be compensated financially, then let the consumer pay for the system. A Professional Liability Adjustment Fee (PLAF; I coined the term in an 1983 editorial) of say $5.00 should be collected on every patient visit or service. The PLAF would establish a state reinsurance fund that would pay for excess awards over the basic coverage. This concept is very similar to the Patients Compensation Fund (PCF) that found itself millions of dollars in debt. The problem with the PCF was that there was no limitation on the size of the awards paid out and when the fund needed more money, they simply assessed the doctors. My proposal allows those who are receiving the benefit (the public) to pay for the system. As the awards increase in frequency and amount, the PLAF would have to rise to keep the fund solvent. I have a hunch that before long, either the state or those footing the bill would be demanding changes. It is a fact of political life that thousands of irate consumers have a lot more clout than a handful of doctors. It is time we let the public fight our battles for us.

Lee A. Fischer, M.D.
West Palm Beach

Power politics — guilt as a weapon

Throughout the history of nations and their interactions with one another, it is clear that psychology and sociology play as large a role as do legal and treaty obligations. The importance of these entities and the relations of nations are seen in many instances. Most nations have engaged in psychological approaches during warfare or in times of strained relations with other governments to attempt to influence both their own citizens and the adversary. The United States used this approach to great advantage in World War II against both Japan and Germany. Many historians have said that the attack by the Japanese on Pearl Harbor was the death knell for Japan when the Japanese failed to bring America to its knees on that fateful day, because by initiating the attack and then not winning in the initial thrust, it united America against Japan in a moral war. It awakened an industrial giant and galvanized the American people in a concerted front with one purpose — to defeat the Japanese supremely, completely and totally. It was a feeling that Americans had been victimized by an immoral country and ruthless people. While the impetus for this feeling was the Japanese leaders who planned and initiated the attack, it was to the advantage of the United States government that this feeling be strengthened and perpetuated. Out of this milieu would come hundreds of war movies with Americans playing the role as heroes and Japanese as villains. This was a natural development and one which would be expected. The Japanese did the same thing, as did Britain against Germany in World War I, Russia against the United States in Vietnam, and the United States against Russia in Afghanistan.

In studying the actions of government, international politics and psychology it is almost an axiom that one of the principles of being successful in relations with other countries is to invoke your aims with a higher purpose, such as being able to acclaim a religious authority on your side, such as the Crusades, or a moral principle, such as protecting against the aggressions of Communism, which led the United States into Vietnam. An added advantage is to attribute immoral, ungodly principles to your opponents. The best possible scenario is to be able to successfully convince others of your own moral or righteous position while displaying to the world the undeniable, immoral approach of those who oppose you.

Of course the whole scene is familiar to most people as the same sociological and psychological relations exist in other organizations and in individual relationships. Another way of viewing this power politics is to see that if a person or entity cannot only convince themselves of their moral superiority, but convince their opponent of his immoral position and

instill a sense of guilt, then the position of that opponent will immediately lose credibility. It is difficult to argue convincingly when faced with past sins and a cloak of guilt. Once a party has admitted to guilt to the degree that it paralyzes action, the next step is self-flagellation. At that point that person or entity will have a difficult time defending its position or initiating any positive action of its own.

What does all of this have to do with medicine? I have recently been thinking of my previous studies in international affairs after I read the most recent account of the Tax Study Commission and the appearance of the representatives of the Florida Medical Association before that body. To refresh everyone's memory, the Tax Study Commission was created at the direction of the Florida Legislature to review hundreds of tax exemptions which will expire in July of 1987, and which if not specifically reinstated by the Legislature, will no longer apply. These exemptions include hundreds of items for services in various professions such as real estate, law, banking and medicine. Not surprisingly, almost all those affected by the exemptions have requested to be heard before the Commission to present their respective arguments against the end of exemptions. The attorneys have appeared along with other professionals who have presented their own particular arguments.

In the recent meeting of the Commission in Orlando, the Florida Medical Association expressed its point of view and that of course was that medical services should not be taxed. There were many good reasons given for the continued exemptions, such as the fact that medical care is not an optional service, as a person partakes of medical services out of necessity and not particularly out of choice. Failure to avail oneself of medical care at an early stage of a disease because of an added cost may result in danger to the health of that individual and a possible added economic burden both to the individual and to society at a later date when the medical condition may turn into an emergency and the person can no longer procrastinate. These are some of the arguments that the FMA gave to the Commission, all seemingly valid arguments. But obviously, appearance can be deceiving as the members of the Commission listened to the arguments and asked questions. That is, some members listened and asked questions in an effort to find out as much as possible. On the other hand, some members of the Commission asked the FMA representatives what they thought the solution of the monetary problems of the State of Florida should be. The FMA representatives were not able to give the ultimate solution. Small wonder. All the legislators in Florida, various study groups, the Governor and all the king's men have been unable to come up with an economically and politically viable answer to the problem. When the FMA representatives would not give, or could not give the solution, they were rebuked by what newspaper reporters called several angry members of the Commission for arguing against a sales tax on medical services and not having the solution to the overall problem. Is this a fair charge? Does the legal profession have a solution? The real estate profession? The banking industry? Certainly not, not anymore than the Governor or the Legislature. Yet, many professionals and services affected by the proposed sales tax have gone before the Commission. Not being present at the meetings, perhaps they were all chastised for the same perceived shortcomings of the FMA, but I doubt it.

The medical profession and the FMA as an agent of the profession have to deal with this approach, which is an example of power politics as practiced by nations. It is an attempt to convince medicine that it should be covered in guilt and because of this we should be embarrassed or even more advantageous to some, should be made to embarrass ourselves. The psychology of guilt is pervasive, overwhelming and all powerful. It appears to be a constant ploy to use this approach against medicine. If medicine accepts this like an albatross around its neck, it will already have ceded any position of advantage and will constantly be fighting battles from a defensive stance. This is not to say that representatives for the FMA have assumed this position of guilt. Indeed they have not and as far as I know, no one has been able to convince medicine that it should. But this is not from lack of trying and it will be tried again and again.

Medicine has made mistakes, some of which have been major blunders. Hopefully, we have learned from this. Regretful? Yes. Sorrow at past mistakes and missed opportunities? Yes. Guilt for immoral or sinful past? No. We are like all professions, not all good and not all bad, but we are striving to erase the negative and pursue the positive.

We should never fall for a classic power politics move where others, who are in disagreement with us for whatever reason, try to saddle us with a guilt complex. We do not deserve it, should not accept it, but carry on our activities with purpose and mission and continue to present our views in what we believe is the right and correct course of action.

H. Frank Farmer, M.D., Ph.D.
New Smyrna Beach

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In memoriam
Leo M. Wachtel, M.D.
1912 — 1987



Losing a six year battle with that dreaded disease, Leo Michael Wachtel, the 84th President of the Florida Medical Association, expired on February 25, 1987. Born in Savannah, Georgia, and graduating from Emory University, he earned an M.D. degree from Jefferson Medical College in 1938. He interned and did postgraduate training at St. Vincents Hospital in Jacksonville, later becoming president of the medical staff there and for 12 years headed the department of family practice, which he organized. A news item in *The Journal of the Florida Medical Association* in 1941 carried a statement saying that Dr. Leo M. Wachtel and Miss Helen Ross Dixon of Jacksonville were married January 7. His practice was interrupted when, invited to address a reunion of his senior high school class in Savannah, he was severely injured in an automobile accident, and was hospitalized for almost a year, during which his wife was called five times to his bedside with the priest to give "last rites." He recovered to become one of Jacksonville's most outstanding physicians and surgeons for more than 40 years. He served on the Florida State Board of Health under three governors. For 12 years he was a director and treasurer of Blue Shield of Florida, and every year there was standing room only at the breakfast given by Blue Shield to hear his treasurer's report during the annual FMA meeting. His jokes were then told by friends all over the state.

A past president of most every organization to which he belonged, he was a charter member and charter fellow of the American Academy of Family Physicians and he served as its vice president in 1976.

Developing a cough the first year of his retirement, he tried several cough syrups, until his wife reminded him that a good doctor did not treat himself, so he went to a radiologist friend for a chest x-ray. Then began the long successful-for-six-years battle against cancer. Retiring from practice, he wrote his obituary, but he did not stop living. Twice he predicted when he would die. The first time he was way off, but his second prediction he missed only by a day. Two weeks before his death, he was invited to a party, and attending in a wheelchair, as usual immaculate in a blue suit and a bright red tie, he entertained and was entertained by many friends.

Riverside Presbyterian Church, where he had been an elder for many years, and where he had once given a sermon entitled "What Christ Means to Me as a Physician," was packed by devoted patients, friends and associates at his funeral.

He is survived by his wife, Helen Dixon Wachtel, two sons, John D. Wachtel of Jacksonville, and Leo Michael Wachtel III, of McLean, Virginia, and four grandchildren.

Clyde M. Collins, M.D.
Contributing Editor
Jacksonville

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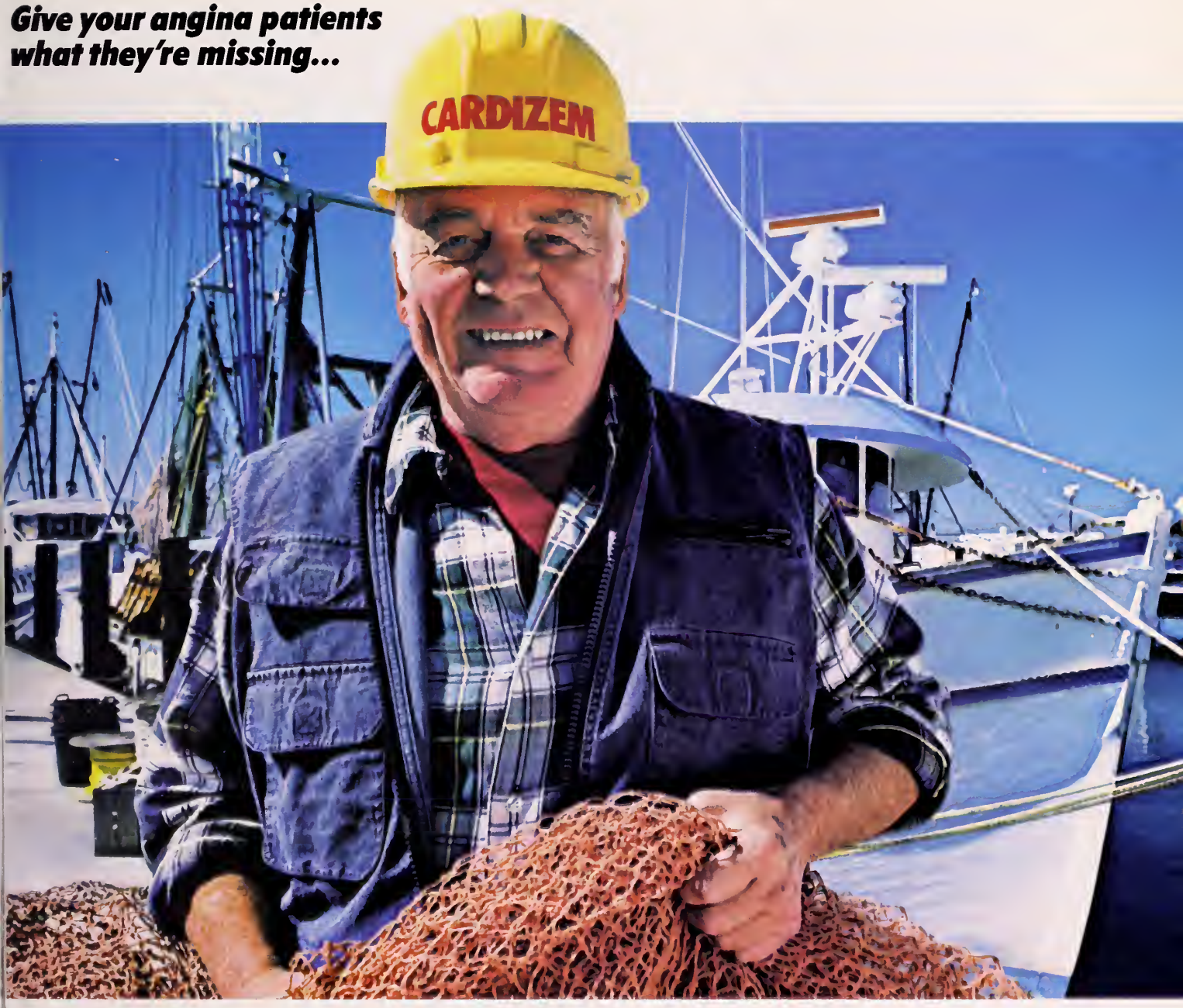
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Please see brief summary of prescribing information on the next page.



CARDIZEM® FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

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Brief Summary
Professional Use Information

CARDIZEM®
(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

See complete Professional Use Information before prescribing.

References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159* ***3.*** *Johnston DL, Lesowoy R, Human DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687* ***4.*** *Cahn PF, Brounwold E: Chronic ischemic heart disease, in Brounwold E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982,50(Sept):94-116*

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INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES

80 mg 120 mg 160 mg



INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS — *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE — *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

1. INDERAL LA National Compliance Evaluation Program. Data on file. Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321-1323.

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Pros and cons on the PRO: the debate continues

I wish to express my anger over a statement that was printed about me by John F. Lee, M.D., of St. Petersburg, in *The Journal of the Florida Medical Association, Inc.*, ("Physicians Should Recognize the PRO for What It Is," Vol. 74, No. 1, January 1987). I resent the fact that *The Journal* allowed such a statement to be printed. I was not afforded the courtesy of an editorial comment as was W.E. Manry Jr., M.D., to whom I had originally responded ("In Defense of Peer Review," *The Journal*, Vol. 73, No. 9, September 1986). "Letters and Viewpoints" should serve as a forum that relates to the issues and not to the individuals who contibute to it. I have nothing against Dr. Lee writing that he felt my letter was "ill conceived rhetoric" but stating that it was "to justify (my) egregious position with the Professional Foundation for Health Care of Tampa" is slanderous and I am offended by that.

Many of Dr. Lee's statements pertaining to the Professional Foundation for Health Care, Inc. (PFHC), which is Florida's Peer Review Organization (PRO), need clarifications. I only wish that *The Journal's* readers had the opportunity to see Dr. Lee's letter in its entirety along with my response now two months later.

First of all, the name of our PRO is not "Professional Foundation for Health Care of Tampa." Dr. Lee was "curious why a group of private physicians of Tampa became the PRO of the State of Florida and why the Florida Medical Association has not been more directly involved in this situation." I would like to clarify the first part of this misconception. The Health Care Financing Administration (HCFA) awarded its federal contract for physician peer review in the State of Florida to the Professional Foundation for Health Care, Inc., a private organization. The PFHC, Inc., is represented by physicians from many subspecialties from all over the state and not just from Tampa. All practicing physicians in the State of Florida are eligible to become PRO members. HCFA felt that the PFHC, Inc., was the most qualified organization in Florida (of those that applied for the contract) to carry out the state's peer review as they (HCFA) would mandate based on federal laws.

The main offices and headquarters of the PFHC, Inc., happen to be located in Tampa, centrally located in the state, to best serve the physicians of Florida. It began with only one medical director, Frank D. Tagliarini, M.D., and now has three: Nelson H. Kraeft, M.D., serves as the director for Division I which represents north Florida; Dr. Tagliarini serves as director of Division II which represents central Florida; and Alan J. Yesner, M.D., serves as the director of Division III which represents south Florida.

Secondly, the Florida Medical Association (FMA) is well represented in the Florida PRO. Frank Coleman, M.D., Past President of the FMA, is also a member of the Board of Trustees of PFHC, Inc. The FMA has a liaison to the PRO and has voiced many opinions regarding PRO activities.

The Professional Foundation for Health Care, Inc., welcomes the opinions and suggestions of all physicians in Florida. What must be kept in mind, however, is that our duties and responsibilities are dictated to us by Uncle Sam (HCFA). Let us make no mistake about it . . . Big Brother is here . . . and plans to stay! Dr. Lee was absolutely correct when he wrote, "It (PFHC) is contracted not by individual patients but by the HCFA for economic reasons." Remember, one of HCFA's middle names is Financing.

Dr. Lee also wrote, "the 'appeals process' . . . is always after the fact and retroactive." I believe this is the standard for due process in our system of law and government. Our (PFHC) processes of approval, denial, appeal and reconciliation are all mandated by federal law. We, the PRO, have been contracted by the HCFA to assure that its rules and regulations of peer review are carried out. Rest assured, Dr. Lee, we physicians who work with the PRO do not like the government intervening into our practices any more than you, but we know that if physicians do not participate in the process now, then possibly non-physicians will control the process in the future . . . and to a large extent, they do already!

Dr. Lee refers to "physicians and their patients involved in acute care situations" being "rewarded by a retroactive denial . . . and a letter to the patient stating 'payment is being denied because the quality of services rendered does not meet professionally recognized standards of health care.'" The Florida PRO has never sent a letter with that wording to any patient and we do not plan to send such a letter. Dr. Lee has mistakenly referred to a draft transmittal of a letter in which federal regulations, provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), gave permission to the PRO to use such a letter with those exact words (remember, those are Uncle Sam's words). The Florida PRO does not plan to use that letter.

Dr. Lee mentioned physician compensation for PRO activities. Those physicians who review patient and hospital records are, indeed, compensated for their time on an hourly basis. The PRO is always looking for good reviewers. The members of the Board of Trustees are not compensated for their hours of service as Board members. They spend many hours, in and out of their offices, on numerous PRO activities that do not involve reviewing charts (e.g., writing editorials).

I am pleased to know that the medical staff that Dr. Lee presides over "rarely" feels that their "quality of service rendered does not meet professional recognized standards of health care." This is exactly what most hospital medical staffs claim. If this were true, our (PRO) job would be a lot easier. We all know that this is not always true and, whether we like it or not, our elected officials in government have promised their constituents, our patients, that Uncle Sam will be the watchdog over medicine and assure quality of care.

One of our PRO's most frustrating problems is that almost everyone is trying his hardest to beat the system instead of joining it. The system is here to stay. Hopefully, we as a PRO can try to modify the present system into a workable compromise between the government that we are contracted to serve and the physicians that we want to represent.

The system is far from perfect, Dr. Lee, but I can guarantee you that Professional Foundation for Health Care, Inc., is absolutely and unequivocally not "concerned solely with management of 'purse strings.'" I invite you to join us and see for yourself.

Charles B. Slonim, M.D.
Board of Trustees
Professional Foundation for Health Care, Inc.
Tampa

I regret that Charles Slonim, M.D., was offended by my letter which was printed in the January issue of *The Journal* under "Letters and Viewpoints." I must underscore the fact that it represents my "viewpoint" alone. I also regret that I did not afford Dr. Slonim the courtesy which he so kindly extended to me when he provided me with a copy of his most recent letter. Unfortunately, this is all new to me. I am not in the habit of writing to *The Journal*. This is but my second letter.

Physicians have an obligation to ensure that those who practice maintain certain minimal standards of the community. This should not be a function of the federal government. Simple record review rarely if ever provides appropriate data regarding quality of care, particularly in a sophisticated medical community such as Florida. Our hospital staffs under the guidance of JCAH all are pursuing quality of care issues. I believe that my fellow physicians are all honorable men and I challenge Dr. Slonim's statement to the contrary.

Morality is not legislated. Dr. Slonim may believe "Big Brother is here . . . and plans to stay," but I do not intend to capitulate to him at the expense of my patients. I remain my patients' advocate and without reference to their finances. I abhor the thought that a physician would be the agent of HCFA whose middle name is financing. I trust that Dr. Slonim and his associates are concerned with quality of care and not strictly economics.

Retrospective review, even through appeals, refused to pay for the one night hospitalization of a blind septugenarian with a pituitary tumor who presented in our emergency room in the late evening with a severley communited fracture of the arm. Dr. Slonim argues this is the standard of due process in our government. Remember, this was the decision of fellow physicians, not nameless bureaucrats or commissars. I feel it inappropriate and I feel this is a profane desecration of the law. If only the PRO had applauded the prudent physician who was afraid to send this patient to her home alone at midnight.

I delight in the Orwellian name of Florida's PRO. The Professional Foundation for Health Care would on the surface never suggest that its major activity is the denial of health care to people previously informed that they are entitled to that care. The mechanism, of course, is one of intimidation, i.e., continually fail

to reimburse providers and, hopefully, they, the doctors and hospitals, will refuse to give care and take the blame.

Dr. Slonim suggests participation as "we physicians who work with the PRO do not like government intervening in our practices any more than you do," yet this logic fails to attack the immorality and injustice of the law. Why compromise? If physicians fail to respond to the call of government, the absurdity of the situation will become more quickly evident. Let nonphysicians deny care to our patients and see what would transpire. Under the present situation, I find it difficult to explain the actions of some of my fellow physicians.

I am sorry, but I must decline Dr. Slonim's kind invitation to join his club. I shall offer him, though, an invitation to meet with me at any appropriate forum (such as a reference committee of the FMA House of Delegates) and debate this topic further, for, you see, my commitment is to cure the sick and comfort the dying, and I intend to remain steadfast to that commitment.

John F. Lee, M.D.
St. Petersburg

Editor's comment: *The Journal* printed Dr. Lee's letter in January in the spirit of fostering a lively exchange of opinions on contemporary issues in medicine. The PRO is one subject that has stirred the passions of physicians everywhere and likely will continue to be heatedly discussed in the future. I regret that Dr. Slonim felt offended by Dr. Lee's letter but no malice or slander was ever intended by publication of the letter.

The Journal, like most magazines, has monthly deadlines to meet and sometimes cannot accommodate an author's response to a letter in the same issue. Where this is the case, *The Journal* will print the response in the next issue.

Dr. Slonim has asured me he is willing and ready to debate Dr. Lee on the PRO issue at an appropriate forum in the near future. It should be an interesting match-up.

Medicare coercing physicians with unfair tactics

It has come to my attention in the last several weeks that Medicare is practicing what I consider to be unethical methods of coercing physicians to become participating doctors in its system.

I have had a number of patients call and come to my office with letters from Medicare giving false information. In essence, each of my patients received rejections for reimbursement of office examinations and procedures which are normally reimbursed under the Medicare system, stating that they did not receive reimbursement because Medicare did not receive additional information from our office. In addition to that, Medicare takes several paragraphs to say that if I were a participating physician in its system, and I accepted assignment, these patients in essence would not have to go through this type of aggravation.

It goes on to insinuate that because I am not a participating physician in Medicare, Medicare then decided to disregard my charges for payment. This type of situation frustrates and aggravates the patients to such a point that they do feel that they may want to go to a participating physician when they are denied their rightful reimbursement. To make things worse, the Medicare office offers a toll-free number for the patients to call for information regarding participating physicians.

I find this a despicable practice. Whether a physician is participating or not should have no bearing on whether office procedures will be considered for payment or reimbursement under the Medicare system. Furthermore, it is unfair that a patient should have to wait several months, in some cases as many as five to six months, to receive this type of rejection letter. I feel that this practice by Medicare is extremely unfair to the patients and all of the physicians, whether they are participating or not. I have discussed this with other colleagues in my area who have been receiving information from patients and copies of letters with the same tactic, and their response has been, "Well, it looks like we are all going to have to become participating physicians because they want to socialize medicine."

Rather than encouraging all physicians to participate in Medicare by taking assignment, we should all stick together and say this is an unfair practice to our colleagues, and we will, in fact, stop becoming participating physicians. If physicians do not have the foresight to stick together now, they will only be hurt in the long term. I truly believe that by my not accepting assignments and conveying to my patients the benefits of private practice, as compared to socialized medicine, the patients will understand and we will continue to be able to practice freely in the American health system.

However, it is essential that all physicians stick together to uphold the values and ideals that we were taught in the practice of our profession. I hope this letter gives other physicians the encouragement and strength to stand together and to reject the government's pressures in forcing us to become participating physicians and eventually socialize medicine completely.

Linda J. Kaplan, M.D.
Hallandale

New approaches to the medical malpractice problem

I have moderated and participated in over a half dozen medical risk management seminars in the past year. We have asked that all speakers in our seminars be critiqued by the participants. Although we have "graded out" good to excellent by over 80% of the participants, there has been a persistent trend throughout the state for many of the participants to feel we only impart a fair amount of helpful information. This group of physicians is probably the most well informed and there is very little new we can impart to this group. There is also a small group of 1% to 2% who feel we give a poor performance and I suspect most of these physicians are disgusted at the idea of paying for a seminar required by state law or have some animosity toward one or all of the speakers.

As a practicing physician, I have so far vetoed the use of plaintiffs' attorneys. I have done this primarily for two reasons, one of which is that I hate to pay the honoraria to our adversaries and prefer to give them to those lawyers who defend us. More important, I do not feel they will as diligently instruct us in what to do to protect ourselves from medical liability. Certainly plaintiff attorneys would be interesting to listen to and it is possible medical risk management will use some plaintiff attorneys in the future. This may well be necessitated to impart some new format to our programs and not bore our audiences with the repetition of prior year's seminars. For in truth, there is only so much that can be imparted that will be beneficial in lowering liability exposure. Most of this centers around the good practice of medicine, a good rapport with patients and good recordkeeping.

Many of the physicians attending our seminars like to be entertained, if not enlightened, by discussion of malpractice suits brought against us. Again there is only so much to be learned from these suits and while it may be good showmanship on the part of our speakers, these presentations do not do much to reduce the exposure to malpractice claims. This brings me to some conclusions made after reading literally thousands of pages of material on the medical malpractice crisis.

As far back as 1970, the Institute for Civil Justice, in making an analysis of professional liability exposure and results, showed that the amount of awards definitely equaled the outcome of the patient's illness or surgery, viz., the more severely the patient was injured, the higher the award. Continuation of this trend has put obstetrics, anesthesiology, neurosurgery and orthopedic surgery at a decided disadvantage in finding affordable malpractice insurance.

Given the fact that these high risk physicians, as well as other physicians, must treat or admit emergency room patients if they are to remain on the staff of their hospital, there should be a means of spreading their malpractice exposure throughout society. Alternatively, their liability should be limited on claims arising from these emergency room situations.

According to present data, limits on damages for pain and suffering, abolishing joint and several liability, capping contingency fees, etc., will only reduce costs 1% to 9%, so further attempts in these areas will do little to alter escalating premiums. There have been other approaches recommended such as a workers compensation approach. The insurance industry maintains that this would be too expensive, and it would be if the physicians had to pay the premium. However, as society continues to accept all maloccurrences as malpractice, I believe society has an obligation to fund these in some fashion. Certainly if society expects us to continue to cover every situation that comes in an emergency room on patients that we have not known prior to that time, then society has an obligation to provide physicians giving those services relief from liability. This can be accomplished by emergency room charges encompassing the costs.

There can be an insurance program that will speak to the issues of maloccurrences and still allow for wanton neglect or disregard for patients' safety to be tried in the tort system. The judiciary would naturally have to take a more narrow approach to torts than they have in the past.

The concept of strict liability will have to be eliminated. Informed consent outlining the patient's awareness of the risk and his willingness to undergo the treatment or procedure recommended needs to be accepted by the court as protection from misadventures or malresults. Again, there can be protection for the injured should there be gross negligence.

Determination of damages as to amount by juries should be abolished. The tort system could be retained to determine liability, but special masters should be used to determine damages.

These thoughts are not offered as absolute solutions but as examples of how there can be some innovative approaches to lower the cost of liability insurance.

As a medical society, we have to educate society at large, and lawmakers in particular, that we cannot long continue to practice under present conditions. If some solution is not found, the current situation will lead to even more difficulty in patients obtaining medical care. When that day finally comes, patients will suffer more than physicians. Hopefully, by seeking further changes in the law, the malpractice crisis can be solved before that day.

Laurie L. Dozier Jr., M.D.
Medical Director
Medical Risk Management
Tallahassee

Policing physicians should begin at county level

I read with interest the article by Dr. Jacott on continuing medical education. I have just completed over 200 hours of CME credits to update myself after 10 years in the practice of Urology.

Over the past 10 years I have averaged between 50 and 100 hours of CME per year. Because of the rapidly changing array of drugs and treatment in all medical fields, we should insist that physicians attend good courses and that the CME hours are relevant to their field of study.

Since fewer physicians are electing to join county medical societies, there does not appear to be any way of policing CME hours except by state law. It is my feeling that it should be mandatory for physicians to belong to a county medical society to practice medicine in Florida.

I also feel that it is the responsibility of the county medical societies to police their members for poor quality medical care. I believe that if we do a better job of this at the county level, the state legislature, the state and federal governments, and review organizations will have a less burdensome task. I believe in local control and local solutions.

Again, thank you for an excellent article. I hope that we will see more thought-provoking articles of this type.

David L. Fromang, M.D.
Fort Pierce

What to do about an impaired driver

An automobile driver may be considered impaired when a physical, mental, or emotional condition reaches a magnitude sufficient to render him potentially hazardous in performing the driving task. We are becoming increasingly aware of this problem as Florida's highways become more crowded. It has been suggested at a state level that Florida physicians be mandated to report patients having seizure disorders.

The Department of Highway Safety has a Medical Advisory Committee. There already are existing guidelines for the reporting of hazardous conditions, along with state-established legal safeguards. Increasing physician awareness of these existing guidelines is the purpose of this communication.

The guidelines are:

1. Florida physicians do not have a legal obligation to report to the Department of Highway Safety persons who may have physical or emotional conditions potentially hazardous to the driving task.
2. Florida physicians do have a moral obligation to their patients, and the citizenry in general, to report to the Department of Highway Safety persons with such conditions as may be hazardous to driving.
3. Florida physicians who do report such patients are protected by the State of Florida (Fl. statute 322.126) from any litigation which could stem from such a report.
4. Any Florida physician who reports a patient with a condition hazardous to the driving task is kept completely anonymous. Neither the physician's name nor the source of the report will be divulged.
5. Physicians wishing further amplification of this protection are urged to contact the Department of Highway Safety, Division of Driver Improvement, Neil Kirkman Building, Tallahassee 32301.

Thomas G. Dickinson, M.D., F.A.C.S.
Member, Medical Advisory Committee
Department of Highway Safety
Sarasota

Bad outcome: the real problem

It is high time that we take the onus of responsibility for the bad occurrences from the physician. We must never again mention the name "malpractice suit." From now on, every physician and his office staff shall call these suits "bad outcome suit." Let us help the public change its perception of what this is all really about. No one need be blamed! Let us focus in now on what is really the problem, i.e., a bad outcome.

Jacob Green, M.D.
Jacksonville

Voice on abortions

I believe it is time for a strong voice to be raised within the medical profession by physicians opposed to the practice of over one million abortions annually in the United States.

Although the scientific fact that human life begins at the time of fertilization of the ovum by the spermatozoon may have been debated in the courts, I believe there would be no controversy that blood cells have been formed in the human fetus prior to even the earliest interruptions of pregnancy. Most would certainly agree that one cannot find a more innocent

person than an unborn human being. Therefore, there is no question whatever that innocent blood is being shed when an abortion is performed. This should be an unconscionable act by any physician who adheres to Judeo-Christian principles of medical ethics.

The medical profession has placed itself in the unenviable position of being the executioners of the unborn and yet organized medicine has been rather strangely silent about the problem, more so than it has been about tobacco or boxing, for example. I hope that physicians against abortion will cease referring patients to abortionists, will express their opinions in their societies, and will take an open stand on this tragedy.

I'd appreciate a copy of any letters that physicians against abortion write you, so that they can be contacted and encouraged. This is an expression of professional concern by a member of the Florida Medical Association.

J. Lawton Smith, M.D.
Miami

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Powerful against susceptible pathogens.*

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Easy on tight budgets.

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Gentle to patients (generally well tolerated).

The one antimicrobial that belongs on every formulary.

Once-a-day Rocephin® ROCHE IV·IM ceftriaxone sodium/Roche

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Rocephin® IV·IM

ceftriaxone sodium/Roche

Before prescribing, please consult complete product information, a summary of which follows:

MICROBIOLOGY: The bactericidal activity of ceftriaxone results from inhibition of cell wall synthesis. Ceftriaxone has a high degree of stability in the presence of beta lactamases, both penicillinases and cephalosporinases, of gram-negative and gram-positive bacteria. Ceftriaxone is usually active against the following microorganisms *in vitro* and in clinical infections (see Indications and Usage):

GRAM-NEGATIVE AEROBES: *Enterobacter aerogenes, Enterobacter cloacae, Escherichia coli, Haemophilus influenzae* (including ampicillin-resistant strains), *H. parainfluenzae, Klebsiella* species (including *K. pneumoniae*), *Neisseria gonorrhoeae* (including penicillinase and nonpenicillinase producing strains), *Neisseria meningitidis, Proteus mirabilis, Proteus vulgaris, Morganella morganii* and *Serratia marcescens*.

Note: Many strains of the above organisms that are multiply resistant to other antibiotics, e.g. penicillins, cephalosporins and aminoglycosides, are susceptible to ceftriaxone sodium.

Ceftriaxone is also active against many strains of *Pseudomonas aeruginosa*.

GRAM-POSITIVE AEROBES: *Staphylococcus aureus* (including penicillinase-producing strains) and *Staphylococcus epidermidis* (Note: methicillin resistant staphylococci are resistant to cephalosporins, including ceftriaxone), *Streptococcus pyogenes* (Group A beta hemolytic streptococci), *Streptococcus agalactiae* (Group B streptococci) and *Streptococcus pneumoniae* (Note: Most strains of enterococci, *Streptococcus faecalis* and Group D streptococci are resistant.)

Ceftriaxone also demonstrates *in vitro* activity against the following microorganisms, although the clinical significance is unknown:

GRAM-NEGATIVE AEROBES: *Citrobacter freundii, Citrobacter diversus, Providencia* species (including *Providencia rettgeri*), *Salmonella* species (including *S. typhi*), *Shigella* species and *Acinetobacter calcoaceticus*.

ANAEROBES: *Bacteroides* species, *Clostridium* species (Note: most strains of *C. difficile* are resistant).

SUSCEPTIBILITY TESTING: Standard susceptibility disk method. Quantitative methods that require measurement of zone diameters give the most precise estimate of antibiotic susceptibility. One such procedure (Bauer AW, Kirby WMM, Sherris JC, Turck M: Antibiotic Susceptibility Testing by a Standardized Single Disk Method, *Am J Clin Pathol* 45: 493-496, 1966, Standardized Disk Susceptibility Test, *Federal Register* 39: 19182-19184, 1974, National Committee for Clinical Laboratory Standards, Approved Standard: ASM-2, Performance Standards for Antimicrobial Disk Susceptibility Tests, July 1975.) has been recommended for use with disks to test susceptibility to ceftriaxone.

Laboratory results of the standardized single-disk susceptibility test using a 30-mcg ceftriaxone disk should be interpreted according to the following three criteria:

1. Susceptible organisms produce zones of 18 mm or greater, indicating that the tested organism is likely to respond to therapy.
2. Organisms that produce zones of 14 to 17 mm are expected to be susceptible if a high dosage (not to exceed 4 gm per day) is used or if the infection is confined to tissues and fluids (e.g., urine), in which high antibiotic levels are attained.
3. Resistant organisms produce zones of 13 mm or less, indicating that other therapy should be selected.

Organisms should be tested with the ceftriaxone disk, since ceftriaxone has been shown by *in vitro* tests to be active against certain strains found resistant to cephalosporin class disks.

Organisms having zones of less than 18 mm around the cephalothin disk are not necessarily of intermediate susceptibility or resistant to ceftriaxone.

Standardized procedures require use of control organisms. The 30-mcg ceftriaxone disk should give zone diameters between 29 and 35 mm, 22 and 28 mm and 17 and 23 mm for the reference strains *E. coli* ATCC 25922, *S. aureus* ATCC 25923 and *P. aeruginosa* ATCC 27853, respectively.

DILUTION TECHNIQUES: Based on the pharmacokinetic profile of ceftriaxone, a bacterial isolate may be considered susceptible if the MIC value for ceftriaxone is not more than 16 mcg/ml. Organisms are considered resistant to ceftriaxone if the MIC is equal to or greater than 64 mcg/ml. Organisms having an MIC value of less than 64 mcg/ml, but greater than 16 mcg/ml, are expected to be susceptible if a high dosage (not to exceed 4 gm per day) is used or if the infection is confined to tissues and fluids (e.g., urine), in which high antibiotic levels are attained.

E. coli ATCC 25922, *S. aureus* ATCC 25923 and *P. aeruginosa* ATCC 27853 are also the recommended reference strains for controlling ceftriaxone dilution tests. Greater than 95% of MICs for the *E. coli* strain should fall within the range of 0.016 to 0.5 mcg/ml. The range for the *S. aureus* strain should be 1 to 2 mcg/ml, while for the *P. aeruginosa* strain the range should be 8 to 64 mcg/ml.

INDICATIONS AND USAGE: Rocephin is indicated for the treatment of the following infections when caused by susceptible organisms:

LOWER RESPIRATORY TRACT INFECTIONS caused by *Strep. pneumoniae, Streptococcus* species (excluding enterococci), *Staph. aureus, H. influenzae, H. parainfluenzae, Klebsiella* species (including *K. pneumoniae*), *E. coli, E. aerogenes, Proteus mirabilis* and *Serratia marcescens*.

SKIN AND SKIN STRUCTURE INFECTIONS caused by *Staph. aureus, Staph. epidermidis, Streptococcus* species (excluding enterococci), *E. cloacae, Klebsiella* species (including *K. pneumoniae*), *Proteus mirabilis* and *Pseudomonas aeruginosa*.

URINARY TRACT INFECTIONS (complicated and uncomplicated) caused by *E. coli, Proteus mirabilis, Proteus vulgaris, M. morganii* and *Klebsiella* species (including *K. pneumoniae*).

UNCOMPLICATED GONORRHEA (cervical/urethral and rectal) caused by *Neisseria gonorrhoeae*, including both penicillinase and nonpenicillinase producing strains.

PELVIC INFLAMMATORY DISEASE caused by *N. gonorrhoeae*.

BACTERIAL SEPTICEMIA caused by *Staph. aureus, Strep. pneumoniae, E. coli, H. influenzae* and *K. pneumoniae*.

BONE AND JOINT INFECTIONS caused by *Staph. aureus, Strep. pneumoniae, Streptococcus* species (excluding enterococci), *E. coli, P. mirabilis, K. pneumoniae* and *Enterobacter* species.

INTRA-ABDOMINAL INFECTIONS caused by *E. coli* and *K. pneumoniae*.

MENINGITIS caused by *H. influenzae, N. meningitidis* and *Strep. pneumoniae*. Ceftriaxone has also been used successfully in a limited number of cases of meningitis and shunt infections caused by *Staph. epidermidis* and *E. coli*.

PROPHYLAXIS: The administration of a single dose of ceftriaxone preoperatively may reduce the incidence of postoperative infections in patients undergoing coronary artery bypass surgery.

Although ceftriaxone has been shown to have been as effective as cefazolin in the prevention of infection following coronary artery bypass surgery, no placebo-controlled trials have been conducted to evaluate any cephalosporin antibiotic in the prevention of infection following coronary artery bypass surgery.

SUSCEPTIBILITY TESTING: Before instituting treatment with Rocephin, appropriate specimens should be obtained for isolation of the causative organism and for determination of its susceptibility to the drug. Therapy may be instituted prior to obtaining results of susceptibility testing.

CONTRAINDICATIONS: Rocephin is contraindicated in patients with known allergy to the cephalosporin class of antibiotics.

WARNINGS: BEFORE THERAPY WITH ROCEPHIN IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS, PENICILLINS OR OTHER DRUGS. THIS PRODUCT SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. ANTIBIOTICS SHOULD BE ADMINISTERED WITH CAUTION TO ANY PATIENT WHO HAS DEMONSTRATED SOME FORM OF ALLERGY, PARTICULARLY TO DRUGS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE THE USE OF SUBCUTANEOUS EPINEPHRINE AND OTHER EMERGENCY MEASURES.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.

ROCEPHIN® (ceftriaxone sodium/Roche)

Treatment with broad spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic associated colitis. Cholestyramine and colestipol resins have been shown to bind to the toxin *in vitro*.

Mild cases of colitis respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated.

When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: *GENERAL*: Although transient elevations of BUN and serum creatinine have been observed, at the recommended dosages, the nephrotoxic potential of Rocephin is similar to that of other cephalosporins.

Ceftriaxone is excreted via both biliary and renal excretion (see Clinical Pharmacology). Therefore, patients with renal failure normally require no adjustment in dosage when usual doses of Rocephin are administered, but concentrations of drug in the serum should be monitored periodically. If evidence of accumulation exists, dosage should be decreased accordingly.

Dosage adjustments should not be necessary in patients with hepatic dysfunction; however, in patients with both hepatic dysfunction and significant renal disease, Rocephin dosage should not exceed 2 gm daily without close monitoring of serum concentrations.

Alterations in prothrombin times have occurred rarely in patients treated with Rocephin. Patients with impaired vitamin K synthesis or low vitamin K stores (e.g., chronic hepatic disease and malnutrition) may require monitoring of prothrombin time during Rocephin treatment. Vitamin K administration (10 mg weekly) may be necessary if the prothrombin time is prolonged before or during therapy.

Prolonged use of Rocephin may result in overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Rocephin should be prescribed with caution in individuals with a history of gastrointestinal disease, especially colitis.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Carcinogenesis: Considering the maximum duration of treatment and the class of the compound, carcinogenicity studies with ceftriaxone in animals have not been performed. The maximum duration of animal toxicity studies was six months.

Mutagenesis: Genetic toxicology tests included the Ames test, a micronucleus test and a test for chromosomal aberrations in human lymphocytes cultured *in vitro* with ceftriaxone. Ceftriaxone showed no potential for mutagenic activity in these studies.

Impairment of Fertility: Ceftriaxone produced no impairment of fertility when given intravenously to rats at daily doses up to 586 mg/kg/day, approximately 20 times the recommended clinical dose of 2 gm/day.

PREGNANCY: Teratogenic Effects: Pregnancy Category B: Reproductive studies have been performed in mice and rats at doses up to 20 times the usual human dose and have no evidence of embryotoxicity, fetotoxicity or teratogenicity. In primates, no embryotoxicity or teratogenicity was demonstrated at a dose approximately three times the human dose.

There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproductive studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nonteratogenic Effects: In rats, in the Segment I (fertility and general reproduction) and Segment III (perinatal and postnatal) studies with intravenously administered ceftriaxone, no adverse effects were noted on various reproductive parameters during gestation and lactation, including postnatal growth, functional behavior and reproductive ability of the offspring, at doses of 586 mg/kg/day or less.

NURSING MOTHERS: Low concentrations of ceftriaxone are excreted in human milk. Caution should be exercised when Rocephin is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness of Rocephin in neonates, infants and children have been established for the dosages described in the Dosage and Administration section.

ADVERSE REACTIONS: Rocephin is generally well tolerated. In clinical trials, the following adverse reactions, which were considered to be related to Rocephin therapy or of uncertain etiology, were observed:

LOCAL REACTIONS—pain, induration or tenderness at the site of injection (1%). Less frequently reported (less than 1%) was phlebitis after I.V. administration.

HYPERSENSITIVITY: rash (1.7%). Less frequently reported (less than 1%) were pruritus, fever or chills.

HEMATOLOGIC—eosinophilia (6%), thrombocytosis (5.1%) and leukopenia (2.1%). Less frequently reported (less than 1%) were anemia, neutropenia, lymphopenia, thrombocytopenia and prolongation of the prothrombin time.

GASTROINTESTINAL: diarrhea (2.7%). Less frequently reported (less than 1%) were nausea or vomiting, and dysgeusia.

HEPATIC—elevations of SGOT (3.1%) or SGPT (3.3%). Less frequently reported (less than 1%) were elevations of alkaline phosphatase and bilirubin.

RENAL—elevations of the BUN (1.2%). Less frequently reported (less than 1%) were elevations of creatinine and the presence of casts in the urine.

CENTRAL NERVOUS SYSTEM: headache or dizziness were reported occasionally (less than 1%).

GENITOURINARY—moniliasis or vaginitis were reported occasionally (less than 1%).

MISCELLANEOUS—diaphoresis and flushing were reported occasionally (less than 1%).

Other rarely observed adverse reactions (less than 0.1%) include leukocytosis, lymphocytosis, monocytosis, basophilia, a decrease in the prothrombin time, jaundice, glycosuria, hematuria, bronchospasm, serum sickness, abdominal pain, colitis, flatulence, dyspepsia, palpitations and epistaxis.

DOSAGE AND ADMINISTRATION: Rocephin may be administered intravenously or intramuscularly. The usual adult daily dose is 1 to 2 gm given once a day (or in equally divided doses twice a day) depending on the type and severity of the infection. The total daily dose should not exceed 4 grams.

For the treatment of serious miscellaneous infections in children, other than meningitis, the recommended total daily dose is 50 to 75 mg/kg (not to exceed 2 grams), given in divided doses every 12 hours.

Generally, Rocephin therapy should be continued for at least two days after the signs and symptoms of infection have disappeared. The usual duration is 4 to 14 days; in complicated infections longer therapy may be required.

In the treatment of meningitis, a daily dose of 100 mg/kg (not to exceed 4 grams), given in divided doses every 12 hours, should be administered with or without a loading dose of 75 mg/kg.

For the treatment of uncomplicated gonococcal infections, a single intramuscular dose of 250 mg is recommended.

For preoperative use (surgical prophylaxis), a single dose of 1 gm administered ½ to 2 hours before surgery is recommended.

When treating infections caused by *Streptococcus pyogenes*, therapy should be continued for at least ten days.

No dosage adjustment is necessary for patients with impairment of renal or hepatic function; however, blood levels should be monitored in patients with severe renal impairment (e.g., dialysis patients) and in patients with both renal and hepatic dysfunctions.

HOW SUPPLIED: Rocephin (ceftriaxone sodium/Roche) is supplied as a sterile crystalline powder in glass vials and piggyback bottles. The following packages are available:

Vials containing 250 mg equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1962-01)

Vials containing 500 mg equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1963-01)

Vials containing 1 gm equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1964-01)

Piggyback bottles containing 1 gm equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1964-03)

Vials containing 2 gm equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1965-01)

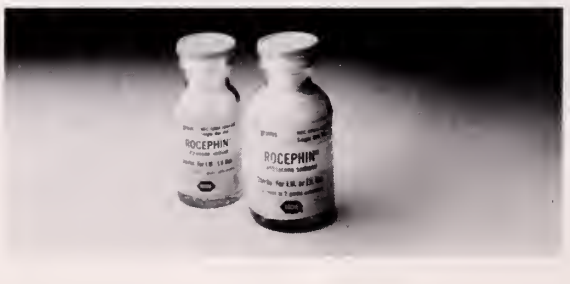
Piggyback bottles containing 2 gm equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1965-03)

Bulk pharmacy containers, containing 10 gm equivalent of ceftriaxone: Boxes of 1 (NDC 0004-1971-01)

NOT FOR DIRECT ADMINISTRATION.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

ROCHE®



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Heterosexuals and the Acquired Immunodeficiency Syndrome: estimating the prevalence of seropositivity among Florida females

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ABSTRACT: Since the presence of antibodies to the human immunodeficiency virus (HIV) is itself not a reportable condition, and since testing for HIV seropositivity often involves self-selected samples, the precise number of persons in the general population infected with the virus which causes AIDS is unknown. The present report discusses a method for estimating this prevalence, and then applies that method to determine the number of Florida females — for the state and by the county — so infected. Females have been under-studied compared with AIDS among men, yet our results suggest that one in every 392 women in Florida manifests HIV seropositivity. Furthermore, over 90% of these cases occur in five counties, including some counties outside the southeast portion of the state. Implications of these findings for studies of HIV prevalence among heterosexuals are also discussed.

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Much of the information on the acquired immunodeficiency syndrome (AIDS) has concentrated on the male homosexual population, as well as other "high-risk" groups such as intravenous drug abusers. Relatively little reliable information is available regarding AIDS prevalence among heterosexuals. For instance, estimates often include males, yet a valid assessment of such cases is problematic due to the likelihood that a homosexual man may report as heterosexual to avoid being stigmatized.[1] Furthermore, while numbers of frank AIDS cases are available,[2] how many instances of seropositivity among heterosexuals are there and how do such numbers compare with the total size of the "at risk" heterosexual population?

In spite of the importance of such issues, our extensive review of the literature uncovered no research whatsoever which identifies the proportion of the heterosexual populace manifesting human immunodeficiency virus (HIV) seropositivity. The present study partially fills this critical gap by focusing on females in Florida. Seropositivity among women provides a good estimation of HIV among heterosexual women because lesbians are not considered a high risk group for AIDS and in any event comprise a small minority of the population.[3] In contrast, using data on males as a basis for gauging heterosexual HIV prevalence is hampered by the likelihood that a homosexual man may claim, for instance, that he contracted HIV from a prostitute.[1] In addition, our focus on Florida is valuable not only to health practitioners but also to the AIDS literature since Florida ranks third among states in the number of AIDS cases.[2]

Method • In order to determine the likelihood that any particular Florida woman will, on the average, have been exposed to the human immunodeficiency

Table 1. — Reported AIDS Cases and Estimated HIV Seropositivity Among Nonpediatric Females, by Florida County.

County*	Reported AIDS Cases[6]	HIV Seropositives**	Population[7]	Seropositives/ Population Ratio
Dade	103	6,608	753,325	1 in 114
Palm Beach	33	2,117	315,011	1 in 149
Broward	25	1,604	503,064	1 in 314
Lee	6	385	115,439	1 in 300
Orange	6	385	227,639	1 in 591
All Others	19	1,219	2,916,838	1 in 2,393

* For confidentiality reasons, counties with five or fewer AIDS cases are aggregated. See text.
** See text.

virus, we must take into account several types of data. First, we must estimate the prevalence of HIV seropositivity among the female population and second, relate these figures to the total female population. In addition to calculating these data for the state, we also present analgous information for counties.

Prevalence of HIV seropositivity among Florida females ● Sivak and Wormser[4] observed that the ratio of the number of living patients with AIDS to the number of persons with HIV antibodies is constant across different patient groups. This constancy also means, of course, that the proportion of U.S. AIDS cases which are Florida cases will be the same as the proportion of U.S. seropositivity cases which are Florida cases. In a similar vein, the ratio of Florida women with AIDS to total Florida AIDS cases will be the same as the ratio of seropositivity in Florida females to seropositivity among the total Florida population. As of November 1986 there were 27,519 cumulative AIDS cases in the U.S.,[5] of which 1,794 were nonpediatric (age 13 or above) Florida cases.[6] Applying this same ratio (1,794 out of 27,519) to the estimated 1,765,470 persons in the U.S. who manifest HIV seropositivity[4] results in 115,093 Florida nonpediatric seropositives. It can further be estimated that 12,318 of these are females. This figure was obtained, following the logic of Sivak and Wormser, by applying the proportion of females (N = 192) among the 1,794 Florida nonpediatric AIDS victims[6] to the estimated 115,093 Florida nonpediatric seropositives, to yield the number (12,318) of those seropositives which are female.

Relating 12,318 female seropositives to the 4,831,316 women age 15 or over in Florida[7] yields a ratio of one out of every 392. However, it should be recognized that in some counties HIV seropositivity in females is much higher than the one in 392 rate. In order to elucidate these geographic variations we have estimated, using the same methodology described previously, the number of adult females with HIV seropositivity in each of a variety of Florida counties (Table 1). At the request of the Florida Department of Health and Rehabilitative Services AIDS Program, which provided the data on AIDS prevalence, counties with five or fewer cases are aggregated in the table to maximally protect patient confidentiality.[6] As the table shows, at least four counties — Dade, Palm Beach, Lee, and Broward — are estimated to have a higher ratio of seropositive females to total female population than is the case statewide. As one example, our calculations indicate that fully one in 114 nonpediatric females in Dade County are seropositive to HIV.

Discussion ● Our findings are important for several reasons. First, they provide estimations of the prevalence of the human immunodeficiency virus rather than merely presenting counts of frank AIDS cases. Sivak and Wormser[4] noted that the presence of HIV antibodies is not itself a reportable condition and, therefore, the number of persons infected with the virus is unknown. Our analysis helps close this research gap and, furthermore, provides prevalence figures specifically for Florida.

Second, our research is valuable because it breaks the Florida prevalence figures down by county. The state has been widely reported third highest in the nation in the number of AIDS cases.[2] However, our findings (Table 1) show that over 90% of HIV seropositivity among women occurs in five Florida counties (Dade, Palm Beach, Broward, Orange, and Lee). Incidentally, not all these "high prevalence" counties are in the southeastern portion of the state. Clearly, recognition of these geographic differences — rather than merely classifying the state as a whole as third highest in AIDS cases — is important to a precise understanding of HIV seropositivity within Florida.

Finally, our study is useful because it addresses the issue of HIV among heterosexuals in a way that other analyses have not. As was stated earlier, estimates of heterosexual AIDS prevalence often include males. However, including males can introduce bias due to the likelihood that a homosexual man may not want to be identified as gay, therefore, may report as heterosexual.[1] For example, many

studies[4] categorize some AIDS patients in "no known risk" group. Yet how many of the persons so classified are heterosexual, and how many on the other hand actually contracted HIV through homosexual contact? In a similar vein, many analyses[2] speak of "heterosexual contact" cases. However, this taxonomy likely underestimates the prevalence of AIDS among heterosexuals, and of heterosexual HIV seropositivity, because some heterosexuals may not have contracted AIDS from sexual activity but rather through intravenous drug abuse or therapeutic transfusion with blood products. By focusing on HIV seropositivity among females, our analysis helps eliminate these methodological difficulties and, therefore, provides a clearer assessment of at least one aspect (females) of heterosexual HIV prevalence.

In conclusion, it should be noted that there are additional aspects of the epidemiology of AIDS and HIV in Florida for which greater elucidation would be helpful, chiefly more accurate delineation of the "at risk" heterosexual population. For example, we calculated our Florida prevalence figure (one seropositive nonpediatric female per each 392 such women) by relating the estimated number of seropositives to the total 15-or-older female populace. While these figures are valid and meaningful, it would also be useful to know how many women are essentially out of the risk pool due to such factors as long-term monogamy with a faithful partner coupled with lack of blood transfusion. Unfortunately, these data are not available. They would, indeed, be a valuable adjunct to studies of HIV prevalence in the state. As research on AIDS continues to burgeon, we feel confident that information of just this type will be forthcoming.

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Pretransfusion testing in Florida — 1985

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ABSTRACT: Pretransfusion testing practices in Florida were evaluated by a questionnaire requesting information on test methodologies designed to detect donor-recipient incompatibility. Certain techniques were universally applied such as ABO and Rh while antibody screening and the major crossmatch showed variation in the reagents and methods utilized. In spite of the extensive national experience on the Maximum Surgical Blood Ordering System (MSBOS), only 16% of respondents had implemented it as a pretransfusion testing policy. Finally, when asked to design their own pretransfusion test battery, the desire to keep the antiglobulin phase of the major crossmatch by a wide majority of respondents (90%) reveals a "conservative" bias in those running transfusion services, even though requirements for such testing have been removed.

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The Technical Productivity Ad Hoc Committee of the Florida Association of Blood Banks (FABB) was established in May 1984 and had as its first charge, "design a questionnaire to determine the level of pretransfusion testing currently in use by institutional members of the FABB." With this goal in mind, the Committee designed a thorough questionnaire which included questions on present transfusion practices and on future plans for pretransfusion testing policies, such as Maximum Surgical Blood Ordering System (MSBOS). Respondents also were asked to design a compatability testing scheme of their choice, based on their own experience, without taking into consideration present regulations or accreditation requirements.

Methods • The questionnaire totaled 45 questions on current transfusion practices and pretransfusion testing policies. Respondents were also asked to design a compatibility test. A copy was sent to all health care facilities with transfusion services in Florida. The questions included requests for figures on workload volumes, pretransfusion testing techniques, reagents and policies for special situations such as medical emergencies, neonatal transfusions and the presence of certain antibodies. The survey also inquired about testing policies for elective surgical procedures. Finally, all participants were asked to "design" a pretransfusion testing procedure of their choice. All answers were tallied and compiled (Table 1). The following is a summary of findings, which provide a comprehensive view of pretransfusion testing practices in Florida in early 1985.

Results • A total of 219 questionnaires were mailed and 115 (53%) responded. Seven percent of the

Table 1. — Total Number of Transfusion Services 107(100%).

I. Workload Volume
- No. Crossmatches: 952,792
- No. Units Transfused: 452,062
- No. Type and Screen Tests: 103,283
- C/T Ratio: 2.1

II. Pretransfusion Testing on Patients
- ABO, Rh and Antibody Screen: 107(100%)
- Autocontrol: 90(88%)
- Major Crossmatch:
 - Testing Phase:
 - RT Incubation: 14(13%)
 - RT Immed. Spin: 101(94%)
 - 37C Incubation: 103(95%)
 - AHG: Polyspec: 91(85%)
 - IgG: 31(29%)
- D^u: 80(79%)
- D^u Positive Patient Gets:
 - Rh Pos Units: 30(38%)
 - Rh Neg Units: 50(62%)
- Enhancement Solutions:
 - Albumin: 74(73%)
 - LISS: 47(44%)
 - Enzymes: 4(3%)
 - Polybrene: 2(2%)

III. Uncrossmatched Units (68 Services)
- Total Transfused 2130 units Hemolytic Reactions: 0
- Blood Type: O Neg: 35% Type Specific: 63%
- O Pos: 2%

IV. If you had a choice . . .
- Antibody Screen:
 - 1 cell: 0
 - 2 cells (pooled): 8(7%)
 - 2 cells (not pooled): 72(67%)
 - 3 cells: 27(26%)
- Major Crossmatch:
 - RT Incubation: 9(8%)
 - RT Immed Spin: 66(62%)
 - 37C Incubation: 66(62%)
 - AHG-Polyspec: 55(51%)
 - AHG-IgG: 23(21%)
- Enhancement Media:
 - Albumin: 52(49%)
 - LISS: 51(48%)
 - Enzymes: 3(02%)
 - Polybrene: 1(01%)
 - Autocontrol: 76(71%)

respondents did not have blood transfusion services "in house." Highlights on cumulative figures are given in Table 1.

Of all transfusion services, almost half were responsible for 100-300 beds (Fig. 1), the overall distribution in bed capacity of respondents being quite similar to that of the entire state.

Compatability testing • The total number of crossmatches obtained by the sum of all respondents workloads during a one year period adds up to a figure close to one million, with about half of those units ending up being transfused (average C/T ratio = 2.1/1). Interestingly enough, the number of type and screen procedures is just above 100,000 with one large institution accounting for more than one fifth of the total.

To nobody's surprise, ABO, Rh, antibody screen and major crossmatch are universally performed. Auto control and D^u testing are done by 79% and 88% of participants.

An analysis of the major crossmatch testing practices is portrayed in Fig. 2. Some practices have been dropped by many, such as room temperature saline incubation and enzyme testing. The excess in percentages seen in the antiglobulin phase are due to some duplications in testing qualified by the respondents with comments such as "if STAT order," or "IgG if DAT of unit positive due to complement." Another interesting finding is that at the time of the survey only two of the respondents performed a major crossmatch by immediate spin only. As for enhancement media, albumin continues to be the most popular in the state (used by 70% of respondents). Similar figures and distribution are found after inquiring about testing phases and enhancement media used when testing for antibody screen. However, when looking at reagent cells used for antibody screening, the differences are minimal (Fig. 3).

A list of generally not clinically significant antibodies, anti-Le, -M, -N, -P, $-A^1$, -HTLA, was given and participants asked about how would they approach this problem. Fifty-two percent responded they would give only antigen negative units. As to the question on whether they would screen the units on hand when

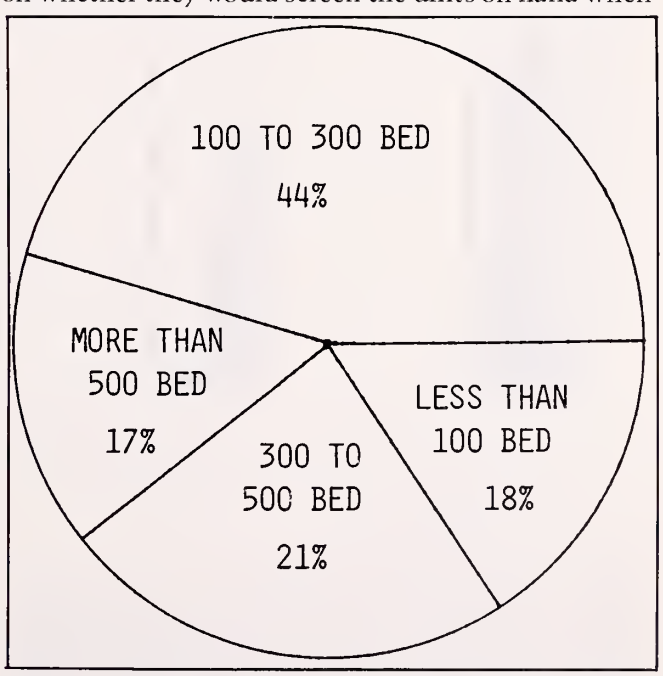


Fig. 1. — Hospital size distribution for all respondent transfusion services (total respondents: 107).

antigen negative cells were needed for clinically significant antibodies, 11% responded that they would go directly to their blood supplier for them, (⅔ from hospitals with 100 beds) while about 60% do it only after screening those on hand.

Neonatal transfusions • As we all know, in most institutions neonatal pretransfusion testing is handled differently when compared with patients over four months of age, and the questionnaire also inquired about these practices. Forty-seven percent of respondents performed transfusions on neonates. The wide variation in the extent of testing is illustrated in Fig. 4. Most institutions (over 94%) perform ABO, Rh and direct antiglobulin tests on the infant's blood. An antibody screen on the mother's sample was also favored by most (over 80%) on initial pretransfusion testing. Over 60% of respondents did perform the crossmatch using mother's sample. Eight services tested "everybody for everything" (Fig. 4). As far as the blood group of units intended for neonates, a majority (60%) has opted for group O red cells. No walk-in donor programs were reported.

Uncrossmatched blood • A total of 2,130 units (or 0.47% of all units transfused reported) were transfused uncrossmatched, with no hemolytic reactions or death attributed to transfusion. As for the blood types infused, almost ⅔ used type specific blood only, 34% O Rh negative only, and 2% O Rh positive.

Pretransfusion testing policies • When asked about MSBOS, only 16% of respondents had implemented

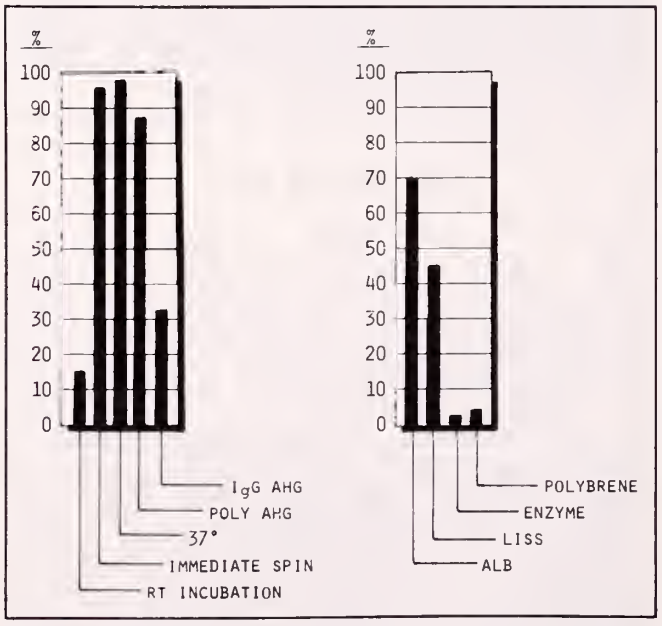


Fig. 2. — Compatibility testing phases (left) and enhancement media (right) as reported by the 102 respondents. Note that some laboratories use both polyspecific or IgG specific antihuman globulin in their procedures, most of them having "decision trees" to make their choice. Same applies to enhancement media (right).

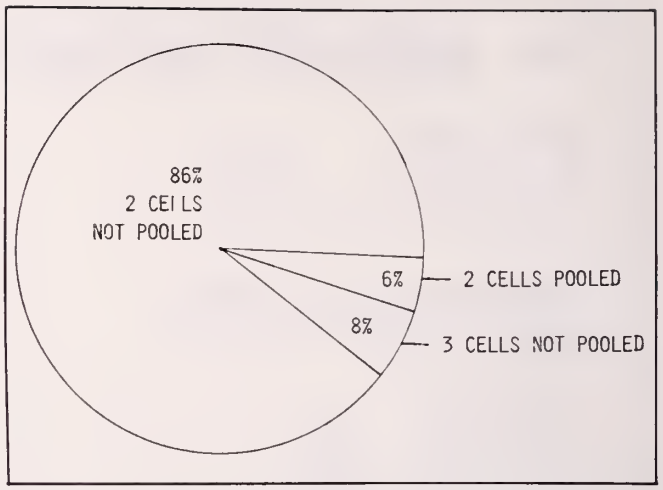


Fig. 3. — Type of reagent cells used for pretransfusion antibody screening.

it with three services reporting that they had discontinued it after implementation. When asked about the impact of MSBOS, although a majority said it had caused changes in inventory management, most felt that it did not affect the C/T ratio as often. The latter finding might be biased since the services most aware of their C/T ratios and, therefore, with lower figures are the ones most likely to have implemented MSBOS. Participants were also asked whether or not there were any plans or interest in implementing MSBOS; most of those surveyed had made no decisions on the subject.

The Technical Productivity Committee has prepared and made available to all members of the Florida Association of Blood Banks a document on the benefits of MSBOS which should help in the evaluation and decision-making process involving this system.

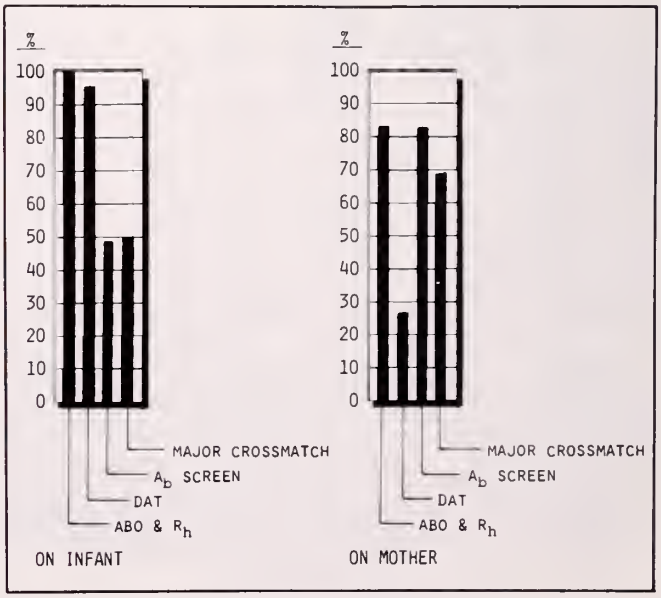


Fig. 4. — Extent of testing in neonatal transfusions, in both infants (left) and mothers (right). In a small percentage of cases, maternal samples are not available to services.

Pretransfusion testing design • The survey concluded by asking, "If you had a choice . . . ," where participants were asked to design their own pretransfusion testing package. The results are as follows:

ABO and Rh were part of pretransfusion testing for everybody.

The antibody screen with two nonpooled cells was a clear favorite.

The major crossmatch should include an autocontrol according to 70% of the respondents.

About 10% of the participants favored a major crossmatch consisting of immediate spin only, while the majority (90%) favored carrying it to an antiglobulin phases (either polyspecific or IgG).

The opinion is divided on enhancement solutions.

Discussion • This survey revealed a somewhat conservative approach to pretransfusion testing procedures in spite of the recent "liberalization" of testing requirements according to the Standards of the American Association of Blood Banks.[1] This may be the result of the present medical liability atmosphere in Florida that is probably pushing those in managerial positions into a "conservative corner." Since this survey was answered almost exclusively by those responsible for transfusion policies in their institutions, the last item on the design of the pretransfusion testing profile may be biased toward the "conservative" view when compared with the supervisor's and bench worker's view.

Studies demonstrating the safety of the immediate spin crossmatch have been published.[2,3] It is the standard of practice in many areas of the country. The advantages are twofold: a decrease in the response time when blood is requested on a typed and screened patient, and a decrease in cost without compromising the safety of transfusion when serologic compatibility is considered. We believe that these advantages will influence the "conservative" position of transfusion services in the state.

Acknowledgment

This study was initiated and supported by the Florida Association of Blood Banks. Special thanks are extended to Donald Doddridge, Past President, and Dorothy Hansen, Executive Director, for their continued support and encouragement.

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Seasonal variations in diagnosis of uterine, ovarian, and cervical malignancies

Guy Benrubi, M.D.; Robert C. Nuss, M.D., and Carole Neuman, M.D.

ABSTRACT: A retrospective study was performed to determine if seasonal variation exists in the diagnosis of uterine, ovarian, and cervical malignancies. A total of 925 patients diagnosed with these malignancies were found listed in the University Hospital, Jacksonville, Gynecologic Tumor Registry from 1976-1985. Both uterine and ovarian malignancies were diagnosed more commonly in the winter and spring, although only the data for ovarian cancer was statistically significant ($p<.05$). Cervical malignancies were diagnosed uniformly throughout the four seasons.

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In a treatise written about 2500 years ago entitled "Airs, Waters, and Places," Hippocrates discussed climate and its effects on man's health. Today, we realize that the close relationship between man and his environment plays an important role in physiologic function of the body and has also influenced the occurrence of various diseases. Circannual variations in incidence have been found for a number of malignancies. Studies have documented a seasonal pattern in the incidence of breast cancer and attributed it to a seasonal endogenous hormonal fluctuation.[1,2] Since hormonal factors have been related to the etiology of adenocarcinoma of the uterus, it is reasonable to look for a potential circannual pattern in this malignancy. According to Kistner, "parallel differences in breast cancer mortality (as compared with ovarian epithelial cell malignancies) suggest a common endocrine background, and females with previously treated carcinomas of the breast or endometrium are more likely to develop a second primary carcinoma of the ovary than at other sites."[3] Furthermore, as ovarian epithelial malignancies are Mullerian in origin a seasonal pattern may occur in the incidence of these tumors.

Materials and methods • This study reviewed all uterine, ovarian, and cervical cancer cases listed in the Gynecologic Tumor Registry at University Hospital in Jacksonville, from 1976 through 1985. During this period, these malignancies were diagnosed in 925 women. Of these, 304 had endometrial carcinoma (261 with adenocarcinoma of the endometrium), 195 had ovarian carcinoma (162 with ovarian epithelial carcinoma), and 426 had cervical carcinomas. Cases for which date of diagnoses were not known were excluded from this analysis.

Table 1. — Site of Malignancy by Season.

Site	Season					P
	Winter	Spring	Summer	Fall	Total	Value
Uterine cancer	82 (26.97%)	88 (28.95%)	72 (23.68%)	62 (20.39%)	304 (100%)	p=.30
Adenocarcinoma	70 (26.82%)	73 (27.97%)	61 (23.37%)	57 (21.84%)	261 (100%)	p=.40
Ovarian cancer	59 (30.26%)	56 (28.72%)	34 (17.44%)	46 (23.59%)	195 (100%)	* p=.005
Epithelial cancer	53 (32.72%)	45 (27.78%)	27 (16.67%)	37 (22.84%)	162 (100%)	* p=.03
Cervical carcinoma	108 (25.35%)	106 (24.88%)	104 (24.41%)	108 (25.35%)	426 (100%)	p=.99

*Denotes statistical significance

The time of year of diagnosis was recorded. The data was analyzed for uterine, ovarian, and cervical carcinomas individually with respect to frequency of site by season. Individual yearly analyses were done as well as a ten year overall analysis. A separate ten year analysis was also done for adenocarcinoma of the uterus and epithelial carcinoma of the ovary. Significance testing was done using the chi-square method.

Results • Table 1 shows the distribution by season of diagnosis of these malignancies over a ten-year period. Winter was defined as December, January, and February, spring as March, April, and May, summer as June, July, and August, autumn as September, October, and November. The table shows that uterine carcinoma is more common in the winter and spring. However, the results are not statistically significant ($p=0.3$). Specifically, adenocarcinomas of the uterus appear to be more common in winter and spring. Again, the results are not statistically significant ($p=0.4$). The table also illustrates that ovarian carcinoma and specifically ovarian epithelial carcinomas are also more common in winter and spring. With ovarian carcinoma, the results are statistically significant ($p<.05$). The table shows that cervical carcinomas are diagnosed with marked uniformity from season to season. In summary, Figure 1 illustrates uterine, ovarian, and cervical carcinomas by season of diagnosis.

Discussion • A review of literature has revealed a number of studies in which seasonal variations were sought in the diagnoses of various malignancies. Hodgkin's disease has been associated with a peak incidence in the month of February and was thought to represent a rare manifestation of a prevalent infection.[4] A study of bladder cancer showed an increased number diagnosed in early spring and autumn.[5] Both skin and ocular melanomas have been associated with a peak incidence in early summer and may perhaps represent a promoter effect of sunlight or a seasonal change in hormonal balance.[6] Seasonality has also been associated with breast cancer. Studying the pattern of the symptomatology of breast cancer, peaks were shown to occur during the spring and troughs during the autumn.[1] In 1976, Hughes et al reported a seasonal pattern of variation for estrogen receptor concentration in breast carcinomas in postmenopausal women.[2] However, this pattern was not confirmed by a subsequent study by Hahnel.[7]

In this study, a possible circannual variation in the diagnosis of uterine, ovarian, and cervical carcinomas is explored. Demographically, our population was a standard population (Tables 2 and 3). The age distribution for each malignancy studied in our population reflects the generally accepted incidence. The fact that more whites than blacks were diagnosed as having each malignancy was probably secondary to the greater number of white patients in the community and referral area.

Since the onset of symptoms can vary according to the individual symptom and since a large subjective component involving recall and other factors exists, month of diagnosis was used in this study. The data for diagnosis of both uterine and ovarian carcinomas seem to indicate a seasonal trend with higher numbers diagnosed in the winter and spring seasons (although only data for ovarian carcinomas are statistically significant.

Confounding variables in these analyses should be considered. A wide variation in tumor mass probably exists at the time of onset of the first symptom, and considerable variation may exist from the time of onset of the first symptom to the actual presentation of the patient to the clinician, and to the time of diagnosis of the malignancy. However, a rapid relative increase in tumor size or psychosocial stresses dependent on time of year may render previously ignorable symptomatology intolerable. Other social factors that may affect season of diagnosis include

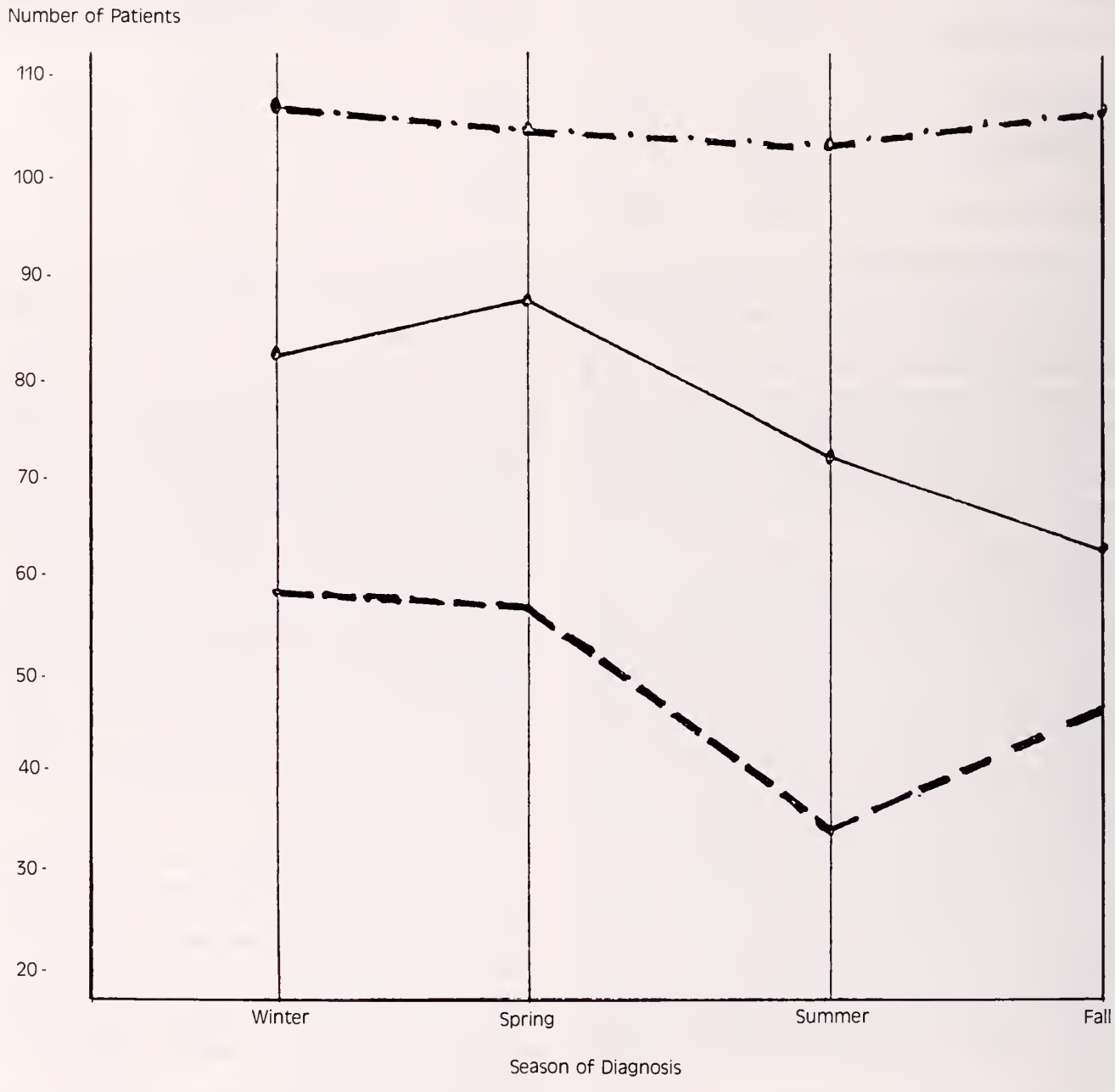


Fig. 1. — Site of malignancy by season.

Table 2. — Site of Malignancy by Age.

Site	Age								
	<20	20-30	30-40	40-50	50-60	60-70	70-80	Unknown	Total
Uterine Cancer	1 (0.33%)	5 1.64%)	14 (4.61%)	29 (9.54%)	71 (23.36%)	115 (37.83%)	45 (14.80%)	24 (7.89%)	304 (100%)
Adenocarcinoma	1 (0.38%)	4 (1.53%)	11 (4.21%)	26 (9.96%)	62 (23.75%)	98 (37.55%)	40 (15.33%)	19 (7.28%)	261 (100%)
Ovarian cancer	8 (4.10%)	10 (5.13%)	11 (5.64%)	37 (18.97%)	60 (30.77%)	41 (21.039%)	23 (11.79%)	5 (2.56%)	195 (100%)
Epithelial cancer	3 (1.85%)	6 (3.70%)	10 (6.17%)	32 (19.75%)	49 (30.25%)	38 (23.46%)	19 (11.73%)	5 (3.09%)	162 (100%)
Cervical carcinoma	6 (1.41%)	40 (9.39%)	79 (18.54%)	74 (17.37%)	85 (19.95%)	78 (18.31%)	48 (11.27%)	16 (3.76%)	426 (100%)

availability of care (vacations by patients as well as physicians). However, in this study, the relative uniformity of diagnosis of cervical carcinomas by season attests to the year-round availability of health care at our institution.

One may postulate that a possible seasonal trend could be due to the well-known phenomenon of holiday depression. Thus, the higher rate of diagnosis during the winter and spring months could be due to a concurrent heightened awareness of somatic symptoms. Mental depression, which is generally thought to modify one's susceptibility to physical illness, may also lead to a decrease in host defenses and a subsequent increase in rate of tumor growth (reflected by onset of symptoms and a visit to the physician).

Of note is the fact that in the diseases where symptomatology is important such as ovarian and uterine cancer a seasonal variation was seen. In the disease whose diagnosis is based on more objective criteria, i.e. pap smear, no variation was found.

Perhaps a winter and spring increase in the diagnosis of endometrial and ovarian carcinoma may reflect an endogenous seasonal change in hormone balance. Female sex hormones may possibly function as promoters of enhanced tumor growth and are primarily responsible for the seasonal patterns.

Table 3. — Site of Malignancy by Race.

Site	Race		
	White	Black	Total
Uterine cancer	225 (74.01%)	79 (25.99%)	304 (100%)
Adenocarcinoma	201 (77.01%)	60 (22.99%)	261 (100%)
Ovarian cancer	151 (77.44%)	44 (22.56%)	195 (100%)
Epithelial cancer	127 (78.40%)	35 (21.60%)	162 (100%)
Cervical carcinoma	264 (61.97%)	162 (38.03%)	426 (100%)

Interestingly, we noted a parallel to Cohen's findings, discussed earlier, of a peak in onset of symptomatology of breast carcinoma in the spring and a trough in the autumn.[4] High estrogen levels are generally a factor in the etiology of both breast and endometrial carcinomas. Females previously diagnosed with carcinomas of breast or endometrium are known to be more likely to develop a second primary carcinoma of the ovary than at other sites.[7]

Circadian and circannual mitotic rhythms have also been observed in carcinomas of various species. For example, mitotic rates observed in both normal cells and cells of renal adenocarcinomas in *Rana pipiens* (leopard frogs) were usually higher during the dark phase of the experimental day. Furthermore, both normal and cancer cells showed the highest mean mitotic rate during the winter, the normal time for hibernation of this species. For the normal cell population, the mean mitotic rate fell throughout the spring and reached a low point in the summer.[8] Perhaps this biorhythm, possibly due to light stimulation of the hypophysis and hypothalamus, may be a factor in the increased rate of diagnosis during the winter and spring months.

The importance of establishing mitotic rhythms in any cancer cannot be overemphasized. Whether a chemotherapeutic agent or radiation will have any effect on the tumor depends on choosing the time that the malignancy is most vulnerable, i.e. while rapidly dividing.

Future study with these malignancies with greater numbers of patients could clarify the data. Studies in other climates or in the southern hemisphere might be of interest. Also, studies of estrogen receptor status of appropriate tumors and relation to time of year of diagnosis would be beneficial.

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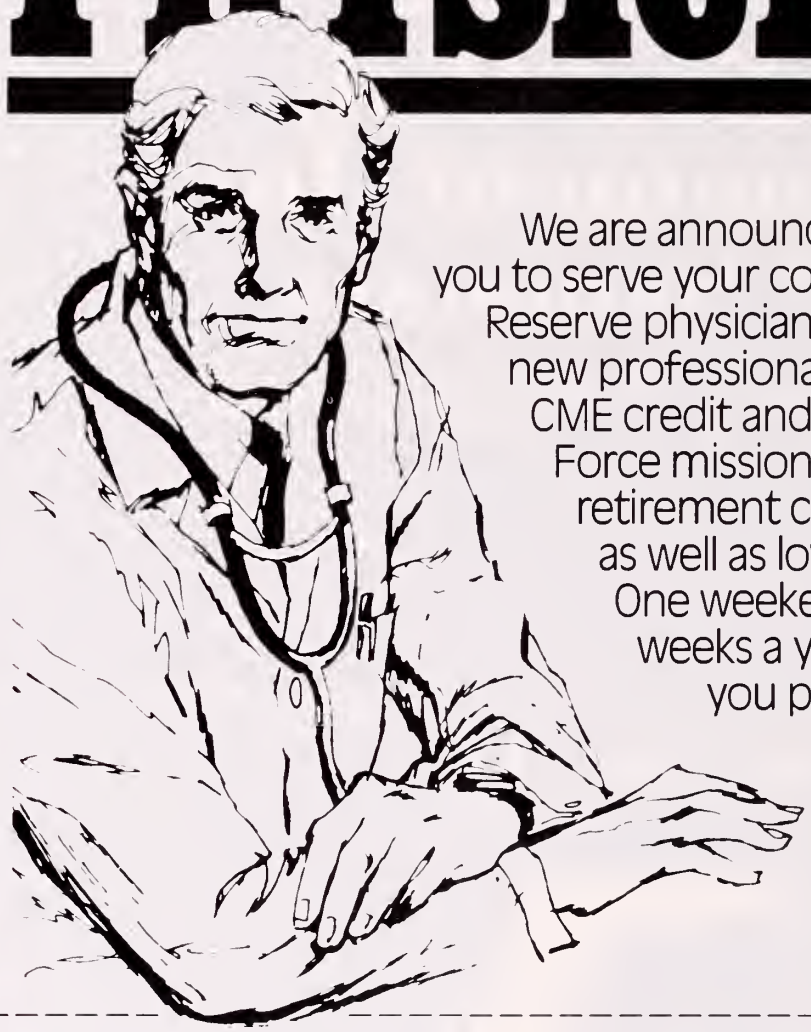
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SPECIAL ARTICLE

An overview of Florida's medical liability in 1984

Joseph F. Phillips, M.D.

Accurate information about the medical liability crisis in Florida has not been readily available to physicians. The Department of Insurance of the State of Florida has been collecting data about medical malpractice cases and the purpose of this paper is to make some of that information available and to do some basic analysis of the facts.

Why 1984? • The year 1984 represents a 12-month period in which common and accurate data are available for population figures, physician and specialty distribution, and medical malpractice claims.

Definitions used in this paper • A claim is a demand for payment and a lawsuit is a prosecution of a claim in a court of law. In this paper, the two terms are used interchangeably although in a strict legal sense they are not entirely synonymous. A closed claim is a claim that has been terminated either by dismissal, successful defense, or payment of indemnity. Indemnity (or payment) is compensation for damages or loss. Indemnity is paid to the plaintiff either through a settlement outside of court or through a judgment following a trial. A plaintiff is a person who brings suit. Expenses are legal cost to prepare and defend a case.

The Data • Table 1 is a presentation of the raw data of this paper. It consists of the general population figures by county, physician and lawyer distribution by county, and data from the Medical Malpractice Closed Claim Study for 1984.

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Column two of this table represents county population figures as of April 1, 1984.[1] Column three shows physician data by county.[2] Column four is the number of lawyers by county.[3]

Columns five through ten represents claims data by county from the Department of Insurance's "Florida Medical Malpractice County Summary for 1984."[4] This study reflects cases closed in 1984 but filed in any year. There is typically a three to four year delay between filing and closing a malpractice case so that the data reflects cases filed several years earlier.

Column five shows the number of claims in each county with "Payment" to a plaintiff either by settlement or by trial. The number of claims that appears in column six "No pay No exp" indicates that claims were reported to the Department of Insurance but were dropped before any expenses were incurred. Column seven shows the number of claims with "Expense Only." These were either dropped during investigation or successfully defended.

Column eight shows "Total Indemnity" and represents total payments to plaintiffs from all the cases in the county. "Indemnity Per Loss" is shown in column nine and is derived by dividing the total indemnity by the number of cases with payment. Column ten represents "Total Cost" and is the sum of total indemnity and expenses for that county.

Table 2 provides a summary of this data by ranking counties according to several variables. The first column ranks counties by average indemnity per loss which is the total indemnity divided by the number of claims with payment. The second column ranks counties by total insurance cost which is the sum of total indemnity plus expenses. The third column ranks counties by the total insurance cost per licensed physician which is column two divided by the number of physicians in that county.

Table 1. — Florida Medical Malpractice Closed Claim Study County Summary 1984.

COUNTY	POPULATION	PHYSICIANS	LAWYERS	CLAIMS WITH: PAYMENT	NO PAY NO EXP.	EXPENSE ONLY	TOTAL INDEMNITY (x $1000)	INDEMNITY PER LOSS (x $1000)	TOTAL COST (x $1000)
ALACHUA	168243	986	447	3	22	15	605	202	715
BAKER	17048	18	3	0	0	1	0	0	0.7
BAY	112949	141	109	3	7	6	430	143	622
BRADFORD	22996	13	11	1	0	0	6	6	8
BREVARD	323055	424	399	7	35	29	671	96	855
BROWARD	1100777	2254	2781	153	54	92	20007	131	22679
CALHOUN	9325	6	7	0	0	0	0	0	0
CHARLOTTE	74060	145	64	4	12	10	228	57	274
CITRUS	68683	72	37	0	3	1	0	0	3
CLAY	79886	152	57	2	2	6	23	12	38
COLLIER	109219	180	213	8	11	19	318	40	506
COLUMBIA	38592	59	61	3	1	12	443	148	533
DADE	1744113	5724	6838	181	103	179	24019	133	27628
DE SOTO	21125	40	19	0	1	2	0	0	1
DIXIE	9125	4	2	0	0	0	0	0	0
DUVAL	605680	1287	1405	28	106	64	2601	93	3443
ESCAMBIA	256715	512	345	2	4	4	101	51	127
FLAGLER	14811	13	16	0	2	0	0	0	0
FRANKLIN	8254	6	8	0	0	0	0	0	0
GADSDEN	43851	54	41	1	1	2	345	345	371
GILCHRIST	7031	2	8	0	0	0	0	0	0
GLADES	6590	2	2	0	0	0	0	0	0
GULF	11073	9	8	0	1	0	0	0	0
HAMILTON	9156	5	8	0	0	0	0	0	0
HARDEE	20803	12	9	0	0	0	0	0	0
HENDRY	21668	19	16	0	0	2	0	0	0.6
HERNANDO	61945	55	25	1	1	5	188	188	240
HIGHLAND	56009	81	45	2	4	2	425	213	462
HILLSBOROUGH	721990	1638	1694	52	86	58	4593	88	5476
HOLMES	15356	7	6	0	1	0	0	0	0
INDIAN RIVER	74162	147	122	4	8	7	389	97	432
JACKSON	39938	31	22	0	1	1	0	0	0.3
JEFFERSON	11395	5	15	0	1	0	0	0	0
LAFAYETTE	4356	1	2	0	0	0	0	0	0
LAKE	119902	139	123	6	14	13	254	42	311
LEE	251768	398	369	5	32	25	380	76	525
LEON	163266	354	1249	10	9	25	1559	156	1842
LEVY	21942	14	13	0	1	0	0	0	0
LIBERTY	4454	1	0	0	0	0	0	0	0
MADISON	15427	11	10	0	0	0	0	0	0
MANATEE	165515	256	196	5	40	26	201	40	261
MARION	148864	166	170	2	19	19	30	15	143
MARTIN	77519	143	141	7	8	16	361	52	612
MONROE	68752	109	138	7	1	5	270	39	619
NASSAU	37690	28	18	0	1	0	0	0	0
OKALOOSA	128941	172	124	5	6	10	1317	263	1398
OKEECHOBEE	23876	21	19	1	0	2	51	51	104
ORANGE	530424	1032	1468	39	61	63	3646	93	4266
OSCEOLA	69955	61	48	4	8	10	83	21	127
PALM BEACH	682638	1363	1714	35	73	79	4250	121	5519
PASCO	225821	221	147	4	41	17	612	153	694
PINELLAS	783265	1424	1467	49	116	61	3773	77	4471
POLK	355413	504	444	10	35	21	3895	390	4062
PUTNAM	55235	44	52	1	3	2	5	5	33
ST. JOHNS	64143	92	60	3	4	2	1050	350	1080
ST. LUCIE	111165	126	100	3	14	12	67	22	271
SANTA ROSA	61842	62	31	0	0	1	0	0	0.1
SARASOTA	231153	507	521	5	32	37	165	33	376
SEMINOLE	214870	282	200	4	20	21	520	130	599
SUMTER	26522	6	16	0	0	0	0	0	0
SUWANNEE	24816	15	24	0	1	0	0	0	0
TAYLOR	17605	13	12	1	4	3	5	5	50
UNION	10489	14	5	0	0	0	0	0	0
VOLUSIA	295368	432	482	11	30	40	875	80	1209
WAKULLA	12691	4	10	0	0	0	0	0	0
WALTON	24217	12	13	5	0	5	1670	334	2232
WASHINGTON	14860	9	7	0	0	0	0	0	0
TOTAL	10930389	19700	24236	677	1040	1033	80443	118	95239

Table 2. — Florida Medical Malpractice Closed Claim Study Sorted County Summary 1984.

AVERAGE INDEMNITY PER LOSS (x $1000)		TOTAL INSURANCE COST (INDEMNITY + EXPENSES) (x $1000)		TOTAL INSURANCE COST PER PHYSICIAN	
POLK	390	DADE	27628	WALTON	186000
ST. JOHNS	350	BROWARD	22679	ST. JOHNS	11739
GADSDEN	345	PALM BEACH	5519	BROWARD	10062
WALTON	334	HILLSBOROUGH	5476	COLUMBIA	9034
OKALOOSA	263	PINELLAS	4471	OKALOOSA	8128
HIGHLAND	213	ORANGE	4266	POLK	8060
ALACHUA	202	POLK	4062	GADSDEN	6870
HERNANDO	188	DUVAL	3443	HIGHLAND	5704
LEON	156	WALTON	2232	MONROE	5679
PASCO	153	LEON	1842	LEON	5203
COLUMBIA	148	OKALOOSA	1398	OKEECHOBEE	4952
BAY	143	VOLUSIA	1209	DADE	4827
DADE	133	ST. JOHNS	1080	BAY	4411
BROWARD	131	BREVARD	855	HERNANDO	4364
SEMINOLE	130	ALACHUA	715	MARTIN	4280
PALM BEACH	121	PASCO	694	ORANGE	4134
INDIAN RIVER	97	BAY	622	PALM BEACH	4049
BREVARD	96	MONROE	619	TAYLOR	3846
ORANGE	93	MARTIN	612	HILLSBOROUGH	3343
DUVAL	93	SEMINOLE	599	PASCO	3140
HILLSBOROUGH	88	COLUMBIA	533	PINELLAS	3140
VOLUSIA	80	LEE	525	INDIAN RIVER	2939
PINELLAS	77	COLLIER	506	COLLIER	2811
LEE	76	HIGHLAND	462	VOLUSIA	2799
CHARLOTTE	57	INDIAN RIVER	432	DUVAL	2675
MARTIN	52	SARASOTA	376	LAKE	2237
OKEECHOBEE	51	GADSDEN	371	ST. LUCIE	2151
ESCAMBIA	51	LAKE	311	SEMINOLE	2124
LAKE	42	CHARLOTTE	274	OSCEOLA	2082
MANATEE	40	ST. LUCIE	271	BREVARD	2017
COLLIER	40	MANATEE	261	CHARLOTTE	1890
MONROE	39	HERNANDO	240	LEE	1319
SARASOTA	33	MARION	143	MANATEE	1020
ST. LUCIE	22	OSCEOLA	127	MARION	861
OSCEOLA	21	ESCAMBIA	127	PUTMAN	750
MARION	15	OKEECHOBEE	104	SARASOTA	742
CLAY	12	TAYLOR	50	ALACHUA	725
BRADFORD	6	CLAY	38	BRADFORD	615
PUTMAN	5	PUTMAN	33	CLAY	250
TAYLOR	5	BRADFORD	8	ESCAMBIA	248
BAKER	0	CITRUS	3	CITRUS	42
CALHOUN	0	DE SOTO	1	BAKER	39
CITRUS	0	BAKER	0.7	HENORY	32
DE SOTO	0	HENORY	0.6	DE SOTO	25
DIXIE	0	JACKSON	0.3	JACKSON	10
FLAGLER	0	SANTA ROSA	0.1	SANTA ROSA	2
FRANKLIN	0	CALHOUN	0	CALHOUN	0
GILCHRIST	0	DIXIE	0	DIXIE	0
GLADES	0	FLAGLER	0	FLAGLER	0
GULF	0	FRANKLIN	0	FRANKLIN	0
HAMILTON	0	GILCHRIST	0	GILCHRIST	0
HARDEE	0	GLADES	0	GLADES	0
HENDRY	0	GULF	0	GULF	0
HOLMES	0	HAMILTON	0	HAMILTON	0
JACKSON	0	HARDEE	0	HARDEE	0
JEFFERSON	0	HOLMES	0	HOLMES	0
LAFAYETTE	0	JEFFERSON	0	JEFFERSON	0
LEVY	0	LAFAYETTE	0	LAFAYETTE	0
LIBERTY	0	LEVY	0	LEVY	0
MADISON	0	LIBERTY	0	LIBERTY	0
NASSAU	0	MADISON	0	MADISON	0
SANTA ROSA	0	NASSAU	0	NASSAU	0
SUMTER	0	SUMTER	0	SUMTER	0
SUWANNEE	0	SUWANNEE	0	SUWANNEE	0
UNION	0	UNION	0	UNION	0
WAKULLA	0	WAKULLA	0	WAKULLA	0
WASHINGTON	0	WASHINGTON	0	WASHINGTON	0

AVERAGE COST OF INSURANCE PER LICENSED PHYSICIAN = $4843.00

Table 3 analyzes several factors from the data. Column one ranks, by county, a physician's chances of being sued during the study period. This figure is derived by dividing the number of claims in the county by the number of physicians. Column two ranks, by county, the physician's chances of losing a lawsuit if one is filed against him. This is derived by dividing the number of claims with payment by the total number of claims. Column three ranks counties by the number of claims filed per 10,000 population and column four ranks counties by the number of claims lost per 10,000 people.

Table 4 presents data by medical specialty. The Department of Insurance performed a "Florida Physicians and Surgeons Specialty Summary 1981-1985."[5] This data has been combined with the number of physicians practicing within each specialty as presented in the article "Florida's Physician Manpower."[6] Note that several specialties do not have manpower data available.

Table 5 ranks data by specialties for the years 1981 through 1985. Column one lists the physician's chances of being sued during that period. One claim per physician equals 100%. Column two ranks the physician's chances of losing a filed claim during the same five year period. Column three ranks average indemnity per loss paid by each specialty during the period.

Discussion • Table 1 shows that physicians and lawyers are roughly distributed along the lines of the general population. There was no apparent correlation between the number of lawyers in a particular county and the number of lawsuits. This is not surprising since only a very small percentage of lawyers specialize in medical malpractice cases. Florida closed 2,750 medical liability cases in 1984 at a total direct cost of $95,239,041. Indemnity payments to plaintiffs totalled $80,443,893 with about one third of that amount going to plaintiff lawyers. Defense expenses totalled $14,795,148 for the year.

Table 2 and Table 3 suggest that the commonly held impression that the medical liability crisis affects mainly our large metropolitan areas, such as Dade and Broward Counties, is wrong. The image of the small town physician being relatively immune from a lawsuit is not born out by the data. Many rural counties rank very high in the chances of a physician being sued and in claims per 10,000 population. It seems that what sets south Florida apart is not that the people are more litigious, but that there is a much higher probability of losing a lawsuit once it has been filed. In addition these areas rank high in average dollar amount of awards. It appears that this combination of factors places these areas in the highest insurance class. The fact that the liability crisis focuses on south Florida may reflect more on the skill of plaintiff lawyers in these areas rather than other factors.

The average direct cost of medical liability insurance per licensed physician in 1984 was $4,834. This cost assumes a 100% efficient insurance system and does not include insurance company overhead and profit which substantially increases the cost of insurance to physicians. An unreferenced newspaper source stated that in 1983 Florida physicians paid $211,000,000 in malpractice insurance premiums with a projected average of $7,700 per insured physician for 1984.

The statistics in this paper also assume that every licensed physician in the state of Florida contributes to the insurance pool. We know that many physicians are in training or research positions and many are employed by governmental agencies. It is estimated that there are about 2,000 physicians in intern, residency, or fellowship positions. There are about 750 physicians in federal institutions such as VA and military hospitals and over 400 doctors working for state agencies.[6]

Table 4 and Table 5 confirm the wide variation in likelihood of being sued according to medical specialty. As expected obstetrics-gynecology, orthopedics, plastic surgery, and neurology plus neurosurgery led the list. Note that many specialty groups averaged more than one lawsuit during the period 1981 to 1985. Note also that the risk of losing a suit and the size of the indemnity did not closely follow the same specialty trends as the chances of being sued. Florida's 20,000 physicians had 11,734 claims filed against them in the five year period.

A drawback of the Department of Insurance specialty data is the failure to group physicians in standard specialty categories. For instance, neurosurgeons and neurologists are grouped together and there are ill-defined specialty groups such as diabetes, cardiovascular and neoplastic diseases. It is hoped that in the future the Department of Insurance will group physicians by specialty areas as determined by the recognized specialty and subspecialty boards.

Other facts to consider • The statistical calculations assume one malpractice case per physician. Although there are a few physicians with multiple malpractice claims the numbers are small and probably do not alter the data significantly.

As previously mentioned, some counties may have large numbers of physicians in training, research positions or employed by governmental agencies. This may alter the significance of the data.

The results from counties with small numbers of people and physicians may not be statistically valid.

Florida has an estimated 39 million visitors annually which equates to an additional 1.333 million permanent residents.[6]

The accuracy of the data and techniques of analysis probably do not permit this to be a precise scientific study, but the information is certainly

Table 3. — Florida Medical Malpractice Closed Claim Study Sorted County Summary 1984.

CHANCES OF BEING SUED		CHANCES OF LOSING YOUR CLAIM		CLAIMS PER 10000 PEOPLE		CLAIMS LOST PER 10000 PEOPLE	
WALTON	83%	BRADFORD	100%	TAYLOR	4.5	WALTON	2.06
TAYLOR	62%	MONROE	54%	MANATEE	4.3	BROWARD	1.39
OSCEOLA	36%	BROWARD	51%	COLUMBIA	4.1	DADE	1.04
PASCO	28%	WALTON	50%	WALTON	4.1	MONROE	1.02
MANATEE	28%	DADE	39%	MARTIN	4.0	MARTIN	0.90
COLUMBIA	27%	ST. JOHNS	33%	CHARLOTTE	3.5	COLUMBIA	0.78
MARION	24%	OKEECHOBEE	33%	COLLIER	3.5	ORANGE	0.74
LAKE	24%	HILLSBOROUGH	27%	DUVAL	3.3	COLLIER	0.73
ST. LUCIE	23%	GADSDEN	25%	SARASOTA	3.2	HILLSBOROUGH	0.72
MARTIN	22%	HIGHLAND	25%	OSCEOLA	3.1	PINELLAS	0.62
COLLIER	21%	ORANGE	24%	ORANGE	3.1	LEON	0.61
JEFFERSON	20%	OKALOOSA	24%	PINELLAS	2.9	OSCEOLA	0.57
VOLUSIA	19%	LEON	23%	LAKE	2.8	TAYLOR	0.57
CHARLOTTE	18%	MARTIN	23%	PASCO	2.7	CHARLOTTE	0.54
BREVARD	17%	PINELLAS	22%	VOLUSIA	2.7	INDIAN RIVER	0.54
SEMINOLE	16%	INDIAN RIVER	21%	PALM BEACH	2.7	PALM BEACH	0.51
PINELLAS	16%	COLLIER	21%	BROWARD	2.7	LAKE	0.50
ORANGE	16%	ESCAMBIA	20%	HILLSBOROUGH	2.7	ST. JOHNS	0.47
LEE	16%	CLAY	20%	LEON	2.7	DUVAL	0.46
DUVAL	15%	BAY	19%	MARION	2.7	BRADFORD	0.43
FLAGLER	15%	COLUMBIA	19%	DADE	2.7	OKEECHOBEE	0.42
SARASOTA	15%	PALM BEACH	19%	ST. LUCIE	2.6	OKALOOSA	0.39
OKEECHOBEE	14%	LAKE	18%	INDIAN RIVER	2.6	VOLUSIA	0.37
HOLMES	14%	OSCEOLA	18%	LEE	2.5	HIGHLAND	0.36
PALM BEACH	14%	PUTMAN	17%	ALACHUA	2.4	MANATEE	0.30
PUTMAN	14%	CHARLOTTE	15%	BREVARD	2.2	POLK	0.29
BROWARD	13%	POLK	15%	SEMINOLE	2.1	ST. LUCIE	0.27
POLK	13%	HERNANDO	14%	MONROE	1.9	BAY	0.27
INDIAN RIVER	13%	DUVAL	14%	POLK	1.9	CLAY	0.25
HERNANDO	13%	VOLUSIA	14%	OKALOOSA	1.6	GADSDEN	0.23
LEON	12%	TAYLOR	13%	HIGHLAND	1.4	BREVARD	0.22
OKALOOSA	12%	ST. LUCIE	10%	DE SOTO	1.4	SARASOTA	0.22
HILLSBOROUGH	12%	BREVARD	10%	BAY	1.4	LEE	0.20
MONROE	12%	SEMINOLE	9%	ST. JOHNS	1.4	SEMINOLE	0.19
BAY	11%	LEE	8%	FLAGLER	1.4	PUTMAN	0.18
GULF	11%	ALACHUA	8%	OKEECHOBEE	1.3	ALACHUA	0.18
HENDRY	11%	MANATEE	7%	CLAY	1.3	PASCO	0.18
HIGHLAND	10%	SARASOTA	7%	HERNANDO	1.1	HERNANDO	0.16
ST. JOHNS	10%	PASCO	6%	PUTMAN	1.1	MARION	0.13
DADE	9%	MARION	5%	HENDRY	0.9	ESCAMBIA	0.09
BRADFORD	8%	BAKER	0%	GADSDEN	0.9	BAKER	0.00
DE SOTO	8%	CALHOUN	0%	GULF	0.9	CALHOUN	0.00
GADSDEN	7%	CITRUS	0%	JEFFERSON	0.9	CITRUS	0.00
LEVY	7%	DE SOTO	0%	HOLMES	0.7	DE SOTO	0.00
SUWANNEE	7%	DIXIE	0%	BAKER	0.6	DIXIE	0.00
CLAY	7%	FLAGLER	0%	CITRUS	0.6	FLAGLER	0.00
JACKSON	6%	FRANKLIN	0%	JACKSON	0.5	FRANKLIN	0.00
CITRUS	6%	GILCHRIST	0%	LEVY	0.5	GILCHRIST	0.00
BAKER	6%	GLADES	0%	BRADFORD	0.4	GLADES	0.00
ALACHUA	4%	GULF	0%	SUWANNEE	0.4	GULF	0.00
NASSAU	4%	HAMILTON	0%	ESCAMBIA	0.4	HAMILTON	0.00
ESCAMBIA	2%	HARDEE	0%	NASSAU	0.3	HARDEE	0.00
SANTA ROSA	2%	HENDRY	0%	SANTA ROSA	0.2	HENDRY	0.00
CALHOUN	0%	HOLMES	0%	CALHOUN	0.0	HOLMES	0.00
DIXIE	0%	JACKSON	0%	DIXIE	0.0	JACKSON	0.00
FRANKLIN	0%	JEFFERSON	0%	FRANKLIN	0.0	JEFFERSON	0.00
GILCHRIST	0%	LAFAYETTE	0%	GILCHRIST	0.0	LAFAYETTE	0.00
GLADES	0%	LEVY	0%	GLADES	0.0	LEVY	0.00
HAMILTON	0%	LIBERTY	0%	HAMILTON	0.0	LIBERTY	0.00
HARDEE	0%	MADISON	0%	HARDEE	0.0	MADISON	0.00
LAFAYETTE	0%	NASSAU	0%	LAFAYETTE	0.0	NASSAU	0.00
LIBERTY	0%	SANTA ROSA	0%	LIBERTY	0.0	SANTA ROSA	0.00
MADISON	0%	SUMTER	0%	MADISON	0.0	SUMTER	0.00
SUMTER	0%	SUWANNEE	0%	SUMTER	0.0	SUWANNEE	0.00
UNION	0%	UNION	0%	UNION	0.0	UNION	0.00
WAKULLA	0%	WAKULLA	0%	WAKULLA	0.0	WAKULLA	0.00
WASHINGTON	0%	WASHINGTON	0%	WASHINGTON	0.0	WASHINGTON	0.00

Table 4. — Florida Medical Malpractice Closed Claim Study By Specialty 1981-1985.

SPECIALTY	NUMBER OF PHYSICIAN	CLAIMS WITH INDEMNITY	CLAIMS NO PAY NO EXP.	CLAIMS EXPENSES ONLY	AVERAGE INDEMNITY PER LOSS (x $1000)	TOTAL INDEMNITY (x $1000)
ALLERGY	97	4	4	2	69.13	276.50
ANESTHESIOLOGY	959	168	145	168	153.82	25841.00
CARDIOVASCULAR	?	71	166	159	125.96	8943.00
DERMATOLOGY	333	48	103	54	46.56	2234.72
DIABETES	?	0	1	0	0.00	0.00
E.M. PHYSICIAN	912	220	248	211	63.31	13928.31
ENDOCRINOLOGY	0	9	2	2	143.11	1288.00
GASTROENTEROLOGY	274	25	49	40	180.90	4522.50
GEN. PRACTICE	3940	298	537	471	88.86	26479.76
GEN. SURGERY	1384	306	383	455	100.60	30783.52
GERIATRIC	?	0	0	1	0.00	0.00
HEMATOLOGY	102	1	5	12	50.00	50.00
INT. MEDICINE	2389	214	561	467	143.88	30789.32
NEOPLASTIC DIS.	?	0	1	0	0.00	0.00
NEPHROLOGY	118	6	13	14	104.81	628.87
NEUROLOGY+SURG.	476	113	170	170	240.15	27136.92
NOT DESIGNATED	?	3	0	2	111.67	335.00
OB GYN	1144	413	554	504	162.81	67239.30
ONCOLOGY	120	1	2	3	25.00	25.00
OPHTHAMOLOGY	803	55	233	139	85.77	4717.22
ORTHOPEDIC	832	311	271	420	120.85	37585.06
OSTEOPATHY	991	169	51	74	107.39	18148.71
OTORHINOLARYN	347	87	95	83	102.94	8955.80
PATHOLOGY	592	33	68	37	127.20	4197.75
PEDIATRIC	1224	108	210	171	171.71	18545.19
PHYSICAL MED.	47	2	2	2	19.25	38.51
PLAST. SURGERY	247	83	103	107	40.59	3369.20
PODIATRY	?	0	1	0	0.00	0.00
PROCTOLOGY	41	3	9	16	14.50	43.50
PSYCHIARTY	1067	8	59	29	92.44	739.50
PUBLIC HEALTH	143	1	3	3	50.00	50.00
RADIOLOGY	979	156	212	265	110.16	17184.36
RHEUMATOLOGY	104	0	4	0	0.00	0.00
THORACIC SURG.	263	31	47	50	84.79	2628.50
UROLOGY	513	65	163	116	58.49	3860.14
TOTAL	20441	3012	4475	4247	2996.63	360565.17

TOTAL CLAIMS 1981 TO 1985 = 11,734

Table 5. — Florida Medical Malpractice Closed Claim Study Sorted by Specialty 1981-1985.

CHANCES OF HAVING A CLAIM		CHANCES OF LOSING		AVERAGE INDEMNITY PER LOSS (x $1000)	
OB GYN	129%	ENDOCRINOLOGY	69%	NEUROLOGY+SURG.	240.15
ORTHOPEDIC	120%	NOT DESIGNATED	60%	GASTROENTEROLOGY	180.90
PLAST. SURGERY	119%	OSTEOPATHY	57%	PEDIATRIC	171.71
NEUROLOGY+SURG.	95%	ALLERGY	40%	OB GYN	162.81
GEN. SURGERY	83%	ANESTHESIOLOGY	35%	ANESTHESIOLOGY	153.82
OTORHINOLARYN	76%	PHYSICAL MED.	33%	INT. MEDICINE	143.88
E.M. PHYSICIAN	74%	OTORHINOLARYN	33%	ENDOCRINOLOGY	143.11
PROCTOLOGY	68%	E.M. PHYSICIAN	32%	PATHOLOGY	127.20
UROLOGY	67%	ORTHOPEDIC	31%	CARDIOVASCULAR	125.96
RADIOLOGY	65%	PLAST. SURGERY	28%	ORTHOPEDIC	120.85
DERMATOLOGY	62%	OB GYN	28%	NOT DESIGNATED	111.67
OPHTHAMOLOGY	53%	GEN. SURGERY	27%	RADIOLOGY	110.16
INT. MEDICINE	52%	NEUROLOGY+SURG.	25%	OSTEOPATHY	107.39
ANESTHESIOLOGY	50%	RADIOLOGY	25%	NEPHROLOGY	104.81
THORACIC SURG.	49%	THORACIC SURG.	24%	OTORHINOLARYN	102.94
GASTROENTEROLOGY	42%	PATHOLOGY	24%	GEN. SURGERY	100.60
PEDIATRIC	40%	DERMATOLOGY	23%	PSYCHIARTY	92.44
GEN. PRACTICE	33%	GEN. PRACTICE	23%	GEN. PRACTICE	88.86
OSTEOPATHY	30%	PEDIATRIC	22%	OPHTHAMOLOGY	85.77
NEPHROLOGY	28%	GASTROENTEROLOGY	22%	THORACIC SURG.	84.79
PATHOLOGY	23%	UROLOGY	19%	ALLERGY	69.13
HEMATOLOGY	18%	NEPHROLOGY	18%	E.M. PHYSICIAN	63.31
PHYSICAL MED.	13%	CARDIOVASCULAR	18%	UROLOGY	58.49
ALLERGY	10%	INT. MEDICINE	17%	HEMATOLOGY	50.00
PSYCHIARTY	9%	ONCOLOGY	17%	PUBLIC HEALTH	50.00
ONCOLOGY	5%	PUBLIC HEALTH	14%	DERMATOLOGY	46.56
PUBLIC HEALTH	5%	OPHTHAMOLOGY	13%	PLAST. SURGERY	40.59
RHEUMATOLOGY	4%	PROCTOLOGY	11%	ONCOLOGY	25.00
ENDOCRINOLOGY	?	PSYCHIARTY	8%	PHYSICAL MED.	19.25
NEOPLASTIC DIS.	?	HEMATOLOGY	6%	PROCTOLOGY	14.50
GERIATRIC	?	RHEUMATOLOGY	0%	PODIATRY	0.00
PODIATRY	?	NEOPLASTIC DIS.	0%	DIABETES	0.00
NOT DESIGNATED	?	PODIATRY	0%	RHEUMATOLOGY	0.00
DIABETES	?	GERIATRIC	0%	GERIATRIC	0.00
CARDIOVASCULAR	?	DIABETES	0%	NEOPLASTIC DIS.	0.00

valid and useful to get a general picture of the medical liability situation in Florida.

Note that there are slight discrepancies between total physician manpower figures calculated by specialty totals (20,441) and the figures given by county totals (19,700). Both include Doctors of Osteopathy.

The analysis by specialty assumes a constant number of physicians for the five year period 1981-1985.

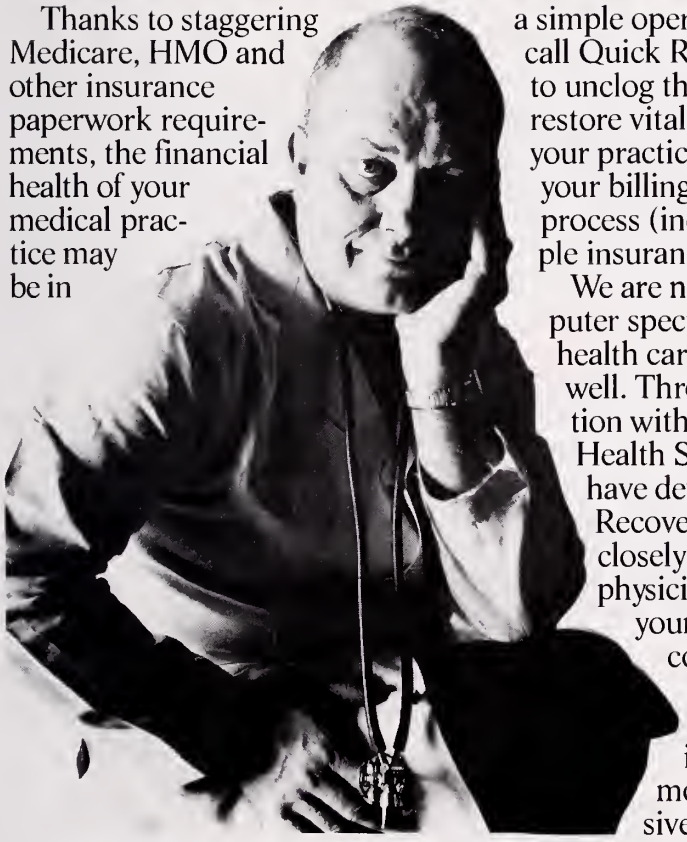
Conclusion • Gathering and analyzing data is one of the key steps in problem solving. As a profession, we must have accurate data to be able to discuss the medical liability problem with our colleagues, patients and the public. This data is also necessary to combat inaccurate information used by people that exploit the current situation.

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DOES YOUR OFFICE NEED A BYPASS OPERATION?



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Significantly reduced risk of endometrial hyperplasia

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PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

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*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

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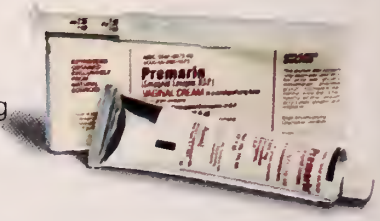
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(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



8RIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION ANO PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1 ESTROGENS HAVE 8EEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent ot the other known risk factors tor endometrial cancer. These studies are further supported by the tinding that incidence rates ot endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13 9 times greater than in nonusers. The risk appears to depend on both duration ot treatment and on estrogen dose. In view ot these tindings, when estrogens are used tor the treatment ot menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration ot low doses ot estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases ot undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT 8E USED DURING PREGNANCY.

The use ot temale sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that temales exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk ot developing in later lite a form ot vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage ot such exposed women (trom 30% to 90%) have been tound to have vaginal adenosis, epithelial changes ot the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use ot other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to temale sex hormones and congenital anomalies, including congenital heart detects and limb reduction defects. One case control study estimated a 4 7-told increased risk of limb reduction detects in intants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days ot treatment. The data suggest that the risk ot limb reduction detects in exposed tetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective tor these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or it the patient becomes pregnant while taking this drug, she should be apprised ot the potential risks to the tetus, and the advisability ot pregnancy continuation

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture ot estrogens, obtained exclusively trom natural sources, blended to represent the average composition of material derived trom pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts ot 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts ot their sulfate esters. Tablets are available in 0 3 mg, 0 625 mg, 0 9 mg, 1 25 mg, and 2 5 mg strengths of conjugated estrogens. Cream is available as 0 625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment ot atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT 8EEN SHOWN TD 8E EFFECTIVE FDR ANY PURPDSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE 8OXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate tor the specific indication should be utilized. Studies of the addition ot a progestin tor 7 or more days ot a cycle ot estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days ot progestin are needed to provide maximal maturation ot the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection trom endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion ot progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice ot progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer ot the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See 8oxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history ot thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment ot breast or prostatic malignancy).

WARNINGS: Long-term continuous administration ot natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk ot carcinoma of the endometrium in humans. (See 8oxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer ot the breast, although a recent study has raised this possibility. There is a need tor caution in prescribing estrogens tor women with a strong family history ot breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses ot estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk ot thrombosis in men receiving estrogens tor prostatic cancer and women tor postpartum breast engorgement. Users ot oral contraceptives have an increased risk ot diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases ot retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users ot oral contraceptives. It feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk ot thromboembolism, or during periods ot prolonged [illegible]. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer ot the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any ot the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening ot glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed tor longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration ot unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence ot mental depression. Patients with a history ot depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. It concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses ot estrogen:

a. Increased sultobromophthalein retention.

b. Increased prothrombin and tactors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (T8G) leading to increased circulating total thyroid hormone, as measured by P8I, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, retlecting the elevated T8G; tree T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

t. Reduced response to metyrapone test.

g. Reduced serum tolate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The tollowing have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size ot uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree ot cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued, erythema multiforme, erythema nodosum; hemorrhagic eruption; loss ot scalp hair, hirsutism; steepening ot corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression; chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation ot porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in temales.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment ot moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1 25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response ot the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis —0 625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored tor signs ot endometrial cancer and appropriate measures taken to rule out malignancy in the event ot persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment ot atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity ot the condition.

Treated patients with an intact uterus should be monitored closely tor signs ot endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event ot persistent or recurring abnormal vaginal bleeding.

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1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects ot estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605 **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824 **3.** Magos AL, 8rincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985, 67: 496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52 **5.** 8arnes R8, Roy S, Lobo RA: Comparison ot lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219

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The 1987 Florida Legislative agenda: a physician's perspective

Several bills, some recently proposed and other unenacted residua from the 1986 Florida legislative session, threaten medicine with future creeping suffocation: a sick tax imposed on physician licensure fees to raise funds for indigent medical care; mandatory acceptance of Medicare and Medicaid assignment as a prerequisite for medical licensure; imposition of sales taxes upon physician services; hospital staff membership for chiropractors; and an extension of the waiver for medical licensure requirements that was granted to the members of the Mayo Clinic, to members of the Cleveland Clinic. These are the major, potentially harmful pieces of legislation that will be considered during the 1987 session. Other medical legislation that will be considered in 1987 include the establishment of a network of trauma centers and a reorganization and construction of a new indigent medical care system. The potential for further consideration of meaningful malpractice tort reform is obscure.

Hopefully the more conservative amalgam of power that has emerged in Tallahassee will provide the FMA with a realistic chance of diverting or defeating the nefarious bills that have been proposed for 1987 and an opportunity for the passage of a more realistic solution to the professional liability crisis in 1988.

The survival of the private practitioner dangles from the willingness of individual physicians to thoroughly master and respond to the political and social issues that jostle the interests of medicine. This article will review the current legislative agenda that impinge upon medical practice in Florida.

Tort reform • The premier legislative concern of the majority of doctors is the professional liability insurance problem. This issue continues to seethe and simmer beneath a legally sanctioned lid imposed by the need to await the report of the Academic Task Force that is not scheduled for release until 1988. This report hopefully will provide the legislature with a set of suggestions concerning the structure and probity of additional alterations in the tort law. The FMA will attempt to accelerate the completion of the Academic Task Force study so that its results will be submitted during 1987 rather than 1988. The emergency room crisis erupting in southern Florida may also advance the study report. Further changes in the malpractice law apparently will not emerge until that report is submitted.

Indigent medical care • A major thrust of the FMA's legislative agenda for the upcoming session will be directed towards the design and implementation of an effective and realistic indigent health care system for the state. This topic was comprehensively examined in the February issue of *The Journal*. Currently the overwhelming majority of the indigent health care dollar is given to hospitals; reimbursement of physicians is so paltry that many doctors cannot afford to provide all the indigent care that their patient population requires. Furthermore, most of the indigent care sponsored by the state is directed towards the Medicaid population — a highly select, very small group which is unrepresentative of the medically needy as a whole. Any new indigent care program must confront the medical needs of a much larger patient base — perhaps providing some type of services to a group as large as 20 to 25% of the Florida population. The costs of such a program will be overwhelming — demanding at least $500,000,000 per year. The proposed methods of financing an indigent care program of such magnitude will be a major area of debate. The FMA supports a financing mechanism

that is broadbased — that taxes all the citizenry and not just the sick or their providers of care. Some legislators would like to assess physicians and hospitals with a "sick tax" in which the doctors would have to pay an additional $500 per year for licensure and the hospitals a fixed percentage of their gross revenues. Another source of income would be sales taxes levied against physician services in the office.

An additional major concern for the indigent care program is the structure of the delivery system. Some have proposed that care for the indigents be contracted out to HMOs or other health care providers who would competitively bid for the state dollars. The FMA has opposed competitive bidding for several reasons: such a system would markedly limit the number of providers and markedly stymie the patient's freedom of choice of providers; the quality of care could not be maintained (a prime example is the current status of the Medicare " at risk" HMO contracts that have been awarded throughout the country in which it has been demonstrated that maintenance of quality care rapidly leads to the financial demise of the HMO and maintenance of financial stability necessitates severe truncation of services); and the resignation of such an important part of health care to the corporate sector, thereby transferring control of a major component of the health care responsibility to non-physician managers.

The FMA supports an indigent care delivery system that is parochially based. Florida law has already provided a mechanism by which indigent care can be coordinated through the county public health care units. Such a system will make the local government and populace responsible for its own indigents and allow a degree of flexibility of care that can be made adaptable to each community's needs.

Mandatory Medicare/Medicaid assignment as a condition for licensure ● The Massachusetts law that requires physicians to accept Medicare's approved ("reasonable") rate as full payment for any Medicare services provided (thus disallowing the right to balance bill the patient) has naturally received considerable support from the state's elderly population. Certain lawmakers have responded with proposed legislation to adapt the Massachusetts law as a condition of licensure for Florida physicians.

There are obvious economic and philosophical reasons for opposing such a law. First, the Medicare "reasonable" rates for services rendered in Massachusetts are much higher than those allowed in Florida. For instance, the Medicare allowable fee for an intermediate office visit in the area north of Boston is $32. In most parts of Florida the allowable fee varies from $18 to 25. In Massachusetts Medicaid reimburses the physicians over $20 for an intermediate visit; in Florida Medicaid reimburses the physicians $0 to $3 for the same service. Massachusetts physicians can cover a greater percentage of their costs with the fee schedule they have. Florida "cognitive" physicians can neither recover their costs nor receive any payment for their services if the proposed legislation and current fee schedules prevail. Passage of this legislation will give Florida physicians three choices: (1) Refuse to serve Medicare and Medicaid patients;(2) Severely curtail time spent and the quality of services rendered to the Medicare/Medicaid population; or (3) financial ruin. The third option is obviously ludicrous. Most physicians will continue to see Medicare and Medicaid patients but will severely limit their services to these patients. Such patients will be assigned to a tier of care which is inferior to that given to patients for whom there is a reasonable remuneration.

There are legal-philosophical reasons for opposing the mandatory assignment bill. Passage of the law allows the states to alter the federally administered Medicare system, limits the rights of physicians to establish fees for their services, and establishes nonmedical criteria for medical licensure.

If the state destroys the health care delivery system by imposing an unrealistic fee schedule upon physicians . . . then the elderly will be denied access to the cognitive skills these doctors offer. Basic economics dictates that one cannot purchase an ounce of gold for the price of an ounce of silver. The Medicare/Medicaid fee schedule will pay for only lead.

There are practical reasons for opposing this legislation. The elderly have a right to purchase the quality and intensity of medical service that they desire just as they have the right to purchase an old or new car, a large or small house, etc. This legislation insultingly assumes that all the elderly are a clone of impoverished incompetents who are incapable of making economic decisions. Health care is a fundamental need of the elderly just as food and shelter are. If the state destroys the health care delivery system by imposing an unrealistic fee schedule upon physicians, particularly the non-procedure oriented physicians, then the elderly will be denied access to the cognitive skills these doctors offer. Basic economics dictates that one cannot purchase an ounce of gold for the price of an ounce of silver. The Medicare/Medicaid fee schedule will pay for only lead. Many elderly patients, with good pensions and a life history of success and access to the market place will come to resent this infringement upon their right to quality care. That quality care cannot be delivered at the current Medicare/Medicaid reimbursement rates.

Furthermore physicians will deeply resent being conscripted into an indigent health care system. The doctors of this state contribute about $500,000,000 of free care each year to the medically needy. If the state deprives the physicians of decent compensation for a large portion of their medical practice then physicians will be economically coerced to significantly shrink their contribution of free care to the citizenry.

Tax on health care professional services • Physician services have been exempt from sales taxes but physician, and other services, will be subjected to these taxes as of July 1, 1987 unless the legislature reinstates this exemption. The repeal of the sales tax exemption will provide $246 million to the general revenues of the state. Such funds could be utilized to fund indigent care.

Obviously the application of the sales tax to physician services increases the costs of funding care upon the sick themselves. If an essential service such as medical care is to be taxed then other essentials such as food should also be taxed. If food is exempted then medical services should be exempted.

Thousands of physicians with credentials, education, and experience equal or superior to those employed by Mayo or the Cleveland Clinic have had to comply with the rigorous licensing requirements of this state. Unless the legislature intends to fulfill the Orwellian allegory that "all pigs are created equal but some more equal than others" it should reject this additional request for licensure immunity.

The repeal of the sales tax exemption will impose certain hardships on physicians and increase their overhead. Not only will the doctor, and ultimately the patient, have to pay for the collection of the tax, but also the taxes are imposed on the amount billed and not on amounts collected. The tax must be paid in the month following the rendering of the service. Physicians and hospitals with large amounts of uncollected billings would not be able to make an adjustment for their uncollected sums until the following year after providing the service. This requirement engenders an additional impediment to hospitals and physicians to care for those unable to pay at the time the service is provided.

Trauma center network • Trauma, the major cause of death prior to age 44, costs $70 to $100 billion nationally per year, and will cause about 7200 deaths in Florida this year. Of these 7200, 40%, or 2900 could be prevented by the establishment of a statewide trauma system. In 1984 the legislature allowed any hospital that declared on an application that it fulfilled certain standards, to be designated as a trauma center. No pre- or post-certification site visits were required and the quality of care was not monitored. As a result, some metropolitan centers have five or more trauma centers when a smaller number might suffice. Trauma care is dependent upon an adequate case load to keep the trauma team and system efficient and competent. Furthermore pediatric trauma cases require specific, specialized skills not present at many currently designated trauma centers.

The FMA had supported the establishment of different trauma regions with a limited number of trauma centers in each region. This proposal was opposed by the Florida Hospital Association whose members have a legitimate fear of losing status and income if they are not selected as a designated center. Some form of compromise will have to be molded if Florida is to have a truly skilled and finely-honed trauma care system.

Preferential licensure for Cleveland Clinic physicians • The 1985 legislature passed a law that exempted physicians from the Mayo Clinic in Rochester, Minnesota, from fulfilling the normal medical licensure requirements for practice in the State of Florida. The language of the law was limited to the Mayo Clinic doctors. The Cleveland Clinic has applied for a similar exemption for its physicians.

The central issue is the fairness of the licensing process. Thousands of physicians with credentials, education, and experience superior to those employed by Mayo or the Cleveland Clinic have had to comply with the rigorous licensing requirements of this state. Unless the legislature intends to fulfill the Orwellian allegory that "all pigs are created equal but some more equal than others" it should reject this additional request for licensure immunity.

In summary, the 1987 Florida legislature should pique the concern of all practicing physicians. We beseech the leadership of each county medical society to identify physicians who may have influence with or who may provide medical care for their local legislators. Hopefully such doctors can be recruited to discuss with their legislators medicine's views on the issues which pertain to the future of quality medical practice within this state. Doctors must not just argue for the blockage or passage of a particular bill; they must thoroughly inspect the innards of the legislation and propose alternatives to those parts of the law that may be disagreeable to us.

Most importantly, physicians must deflect the politician's proclivity to provide Procrustean solutions[1] to problems — solutions that may resolve the political quirks and needs of the legislator but which fail to resolve the issue for which the law was needed. The overhaul of the indigent care system

is an issue that may be subjected to so much political compromise that the form of the final legislation may provide a mere tawdry and superficial refinishing of the current hopeless structure rather than the required dismantling of the present system and its replacement by the erection of a solid new edifice. Physicians will need to provide wise counsel to their legislators if we are to have the medical laws which society requires.

References

1. Procrustes was a mythological Greek bandit endowed with the propensity to torture travellers by physically adapting their bodies to the length of his bed. Those who were too short were stretched; those too long were cleaved to the proper dimension. The history of all arenas of human endeavor is replete with problem solutions that were designed and expedited with similar arbitration and senseless mutilation.

2. I wish to thank Ms. Lucy Mohs, the FMA legislative analyst in the Tallahassee office and Mr. Russell Jackson for their aid in the preparation of this manuscript.

Jacques R. Caldwell, M.D.
Daytona Beach

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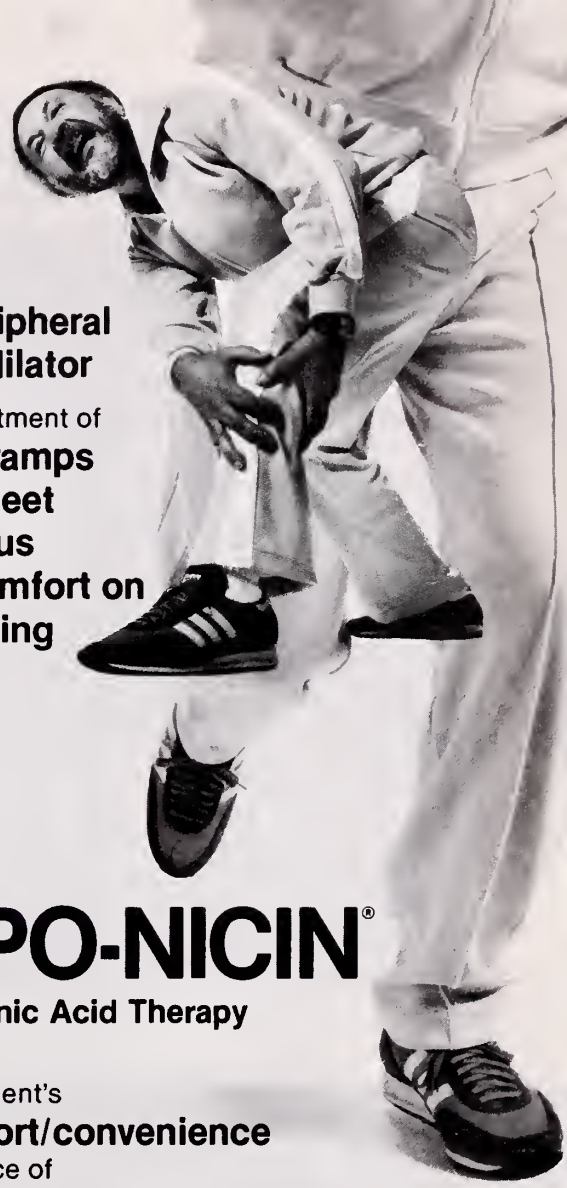
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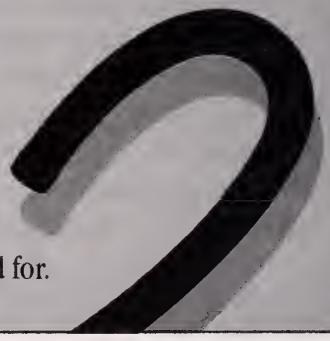
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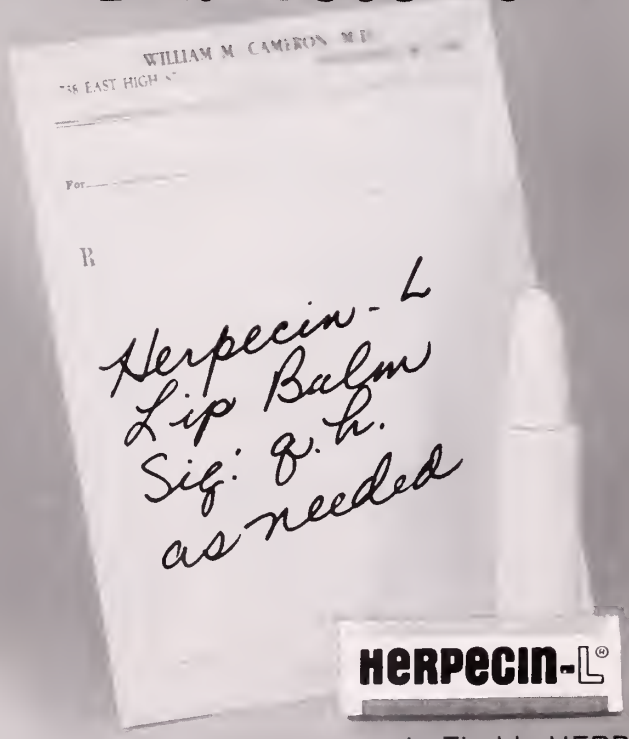
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- ☐ DEAN'S MESSAGE
- ☐ WORTH REPEATING

NOTES & NEWS

Jerome Benson, M.D., receives Sanford A. Mullen Award

Jerome Benson, M.D., was presented with the Sanford A. Mullen Award from the Florida Society of Pathology and Anatomic Pathology recently at the annual conference in Orlando.

Dr. Benson was born in New York City, received his college education at Oberline in Ohio, and his medical degree from Creighton University in Nebraska. His postgraduate education began at the Fordham Hospital in New York and ended at the Mount Sinai Hospital in Miami. He then joined the staff at Mount Sinai Hospital and in 1967 he became Director of Laboratories at Miami Heart Institute, a position in which he remains to date. He is also Chairman of the Blood Services Committee, South Florida region, American Red Cross.

The Sanford A. Mullen Award was established by the Florida Society of Pathologists in honor of Sanford A. Mullen for his public service to pathology in the State of Florida. Recipients of this award have made outstanding contributions to pathology and medicine. Dr. Benson, himself, has risen from a junior member of the Dade County Medical Association to the position of Chairman of the Board of Trustees and has always been renown for his continuing service to the community.

Gerald E. Byrne Jr., M.D., President of the Florida Society of Pathologists, when presenting the award to Dr. Benson said, "I want to present you with the 1986-1987 Sanford A. Mullen Award as an acknowledgement of your never-ending commitment to your profession, your specialty of pathology, and your community."

DEAN'S MESSAGE

"Truisms"

For over 60 years, our distinguished Professor of Medicine and expert on liver disease, Leon Schiff, M.D., has had the pleasure of caring for thousands of patients, conducting biomedical research and, most importantly, teaching young, bright medical students and housestaff. He has always maintained the deepest respect for the voluminous amount of written and audiovisual material available to those being educated. He personally has edited five editions of a book on liver disease, with the sixth edition in press, with his son, Eugene R. Schiff, as co-editor. Nevertheless, he frequently reminds us that as contemporary educators, we often lose sight of some simple common sense rules, admonitions and reflections that abound in the classics and the Bible.

Recently, we had a chance to discuss the art of medicine and he read me what he affectionately calls "Collective Schiffisms" but are, in fact, simple truisms. We decided that if these "Schiffisms" were shared with our students, it would be an excellent reminder to all who provide warmth and compassion to their patients.

"Listen to the patient! He will tell you what is wrong!" — (David Siegel). There is no substitute for a good history and recent data indicates that it takes 19 seconds for a physician to interrupt the patient during a chief complaint.

Always wash hands in the presence of a patient before starting examination and rewash, when the examination is finished. The patient sees that you care and are individualizing their attention.

"Do not touch the patient! Look first. Cultivate your powers of observation." — (Sir William Osler). C.T. and M.R.I.s help, but nothing replaces careful observation.

Promote abdominal relaxation during palpation by directing the patient's thoughts to some pleasant past experience.

Re-examination of the abdomen may detect abnormal findings overlooked on hurried examination or poor relaxation.

"One good feel of the liver is worth any two liver function tests." — (Franklin M. Hanger).

The first feel of the liver is often the best since the presence of liver tenderness will cause the patient to guard against taking subsequent deep breaths.

A single diagnosis to explain the patient's symptoms is more apt to be correct than multiple diagnoses.

"Never say never and never say always. Try to leave yourself plenty of elbow room when you talk with the patient about what you have concluded and what you see ahead." — (Robert F. Loeb).

Never set a definite time limit to a patient's survival. You may be quite embarrassed.

Be wary of the patient who degrades the physician he or she has just left. The same will probably happen to you.

Always instill hope in the patient. "Hope is the most powerful force on earth; it is the only thing that defeats death." — (Eugene O'Neill).

"To thine own self be true — and it must follow, as the night the day, thou canst not then be false to any man." — (William Shakespeare).

"The magic word in medicine is work." — (William Osler).

"Be not the first by whom the new are tried; nor yet the last to cast the old aside." — (Alexander Pope).

"Charm strikes the sight, but merit wins the soul." — (John Bailey).

"Write it on your heart that every day is the best day in the year. He is rich who owns the day and no one owns the day who allows it to be invaded with fret and anxiety. Finish every day and be done with it." — (Ralph Waldo Emerson).

"The physician, as of old, is the student, and even when he becomes the teacher still remains the student." — (Emanuel Libman).

If the simple rules listed above are applied, we can help our patients as much as all of the sophisticated technology that surrounds us and is available for use on a day to day basis.

Leon Schiff, M.D., Ph.D., M.A.C.P.
Professor of Medicine
Division of Hepatology
Department of Medicine
Bernard J. Fogel, M.D.
Vice President for Medical Affairs, and
Dean, School of Medicine
University of Miami

ENCORES!

In pursuit of unity

After graduation from the University of London, I was plunged head-long into the British National Health Service, a system brought about chiefly by disarray in the British Medical Association. The rungs of the ladder were there from lowly house officer to aspiring surgical resident, to an eventual bottleneck at senior registrar level (Chief Resident). One very capable senior registrar I knew had been in the bottleneck for ten years waiting for a hospital consultant post. Truly a case of waiting for a "dead man's shoes!" My choice was to emigrate and complete a graduated four year surgical residency in the U.S.A.

There followed four interesting years in pinewoods pretty Northern Wisconsin doing solo surgical practice with busy resort-filled summers, but long, cold and snowy winters.

I relocated to the Chicagoland area, into a suburban surgical practice for fourteen years, during the tremendous expansion of medical services to the public in the late 60's and 70's. During that period the U.S. national health tab got too high, inflation got too high, and the national economy took a plunge affecting not only medical services, but also to a far greater degree the housing, steel and automobile industries.

The time was right for the promise of the Sunbelt. Climate and opportunity beckoned! The concurrent changing patterns of delivery of medical care enabled a choice of practice systems ranging from the usual fee for service to a whole gamut of arrangements including capitation agreements, negotiated fee scales (with the emerging HMO's), or even fulltime salaried practice. Thank goodness we are still free to choose whichever form of practice we prefer. However, these differences in medical practice have insidiously created differences between us. This is obvious at medical staff level in some hospitals. In the extreme case one can only practice as a "privileged staff" member, without a staff vote in any important general staff issues. (A medical political emasculation!)

No longer can we claim to be united in common purpose, even though as practitioners, we are all subject to the same regulations, whether they be federal, state or local. It seems to me that the ever-increasing onus of medical practice with the legal vultures flying overhead, should draw us closer together, rather than serve to divide us.

Health care experience around the world shows that the splitting of medical ranks is the first essential objective of those that wish to ultimately control the practice of medicine. So why help our foes by artificially dividing ourselves? Let us firmly close our ranks — for our professional survival is also a very necessary duty!

Vernon H. Bartley, M.D.
Tampa, FL

Reprinted with permission from *HCMA Bulletin*, December 1986, Vol. 32, No. 7.

Educate, educate, educate

Whether we physicians agree or disagree, our society has decreed through its collective bureaucracies that a kind of ceiling has been reached for the funding of our health care enterprise. This event is forcing a long needed reappraisal of values we as physicians have taken for granted. How important is it to sustain mere physical existence? Are biotechnological solutions adequate, or even appropriate, in the healing of most illnesses? Can we, as organized medicine, justify these expenditures when so many other needs in our society cry out for funding? Medicine has not been honest about these issues with the larger culture. We have "taken the money and run," as Woody Allen would say. As long

as third parties were around to pick up the tab, we were free to go our merry way, treating the physical manifestations of illness without having to ask too many embarrassing questions about efficacy or cost-effectiveness.

In some sense, the organizations of American medicine bear the same relationship to the body politic that the individual physician bears to his patient. A competent physician educates his patient as part of his treatment. American medicine will regain its preeminence in our society only insofar as it reassumes this vital function of educator about matters medical. This will require a brutal honesty and much soul-searching, for past deficiencies are not easily made up.

Initially, we must tell our constituency that biomedical intervention has been oversold as a solution to the healing of illness. We have not wrought miracles, we have merely performed some amazing technical feats that are only of limited usefulness to a fortunate few. The use of technical solutions as the sole means of treating illness and disease will never "cure" us; not only is this approach doomed to failure, but its wide application carries the substantial risk of generating "...a new kind of suffering: anesthetized, impotent, and solitary survival in a world turned into a hospital ward" (Ivan Illich, *Medical Nemesis*, Pantheon, 1976).

Second, biomedical intervention comes with a price tag, and therefore no one has an absolute "right" to its potential benefits. As a commodity much like automobiles, shoes, deodorant or toilet paper, its price and availability are subject to the law of supply and demand. Only by subsidizing the cost of biomedical intervention through third party payment schemes has the medical care consumer been shielded from the direct economic impact escalating prices secondary to increased utilization.

Third, we must reemphasize how important the role of individual judgement is in deciding on appropriate treatment. Because payment schemes emphasize procedures unduly, experience and judgement have not been accorded their proper place in the medical decision-making process. When to do a procedure, what procedure to do, and how well a procedure is done are of more importance in determining quality care than whether or not a procedure is done.

Fourth, we must reeducate ourselves as to the true nature of the healing transaction. Are we merely biotechnicians, manipulating serum concentrations of chemicals or removing diseased tissue and organ systems? Or can we again become physicians in the sense Jacob Needleman speaks of in his book, *The Way of the Physician* — "a man who has both magnetism and conceptual knowledge...inner being and outer knowledge in stable harmony," offering our patients what only we can give, the healing power of "concentrated attention"?

The physician perspective can be exceedingly valuable to society, for we speak not only as medical experts, but also as sometime patients and knowledgeable citizen taxpayers. Our collective voice will only be heard and heeded, however, when we speak honestly, truthfully and clearly. Self-promotion and media blitzes may seem attractive in the short run, but ultimately they only serve to obfuscate. Instead, the aim of American medicine within the constraints of today's society should be to educate, educate, educate.

R.W. Odell Jr., M.D.
Oakland, CA

Reprinted with permission from *The Western Journal of Medicine*, January 1987, Vol. 146:107-108.

Old attitudes, new realities

If there's anything that is the archetypal new reality within the AMA, it is the reality that there is a new AMA. It is not the same AMA that it has been in the past. It is never going to be the same AMA as it was in the past. Its opportunities are infinite. Its desire to fill those opportunities continues to grow.

It wasn't too long ago that AMA employees thought that an IBM Selectric typewriter was the world's answer to the whole problem of communication. Today, we still have a lot of typewriters at the AMA; not many people use them. Just about everything is done by computer. We not only use computers for writing, but for composing and printing. We even send *AMA News* to the printer by wire. There were and there are some difficulties in that transition and that's understandable. Some people simply can't make that kind of transition, but the fact of the matter is that for the people who did, our writers couldn't be happier. Computer is more efficient, makes jobs easier, saves a lot of time. The old typewriter represents an old attitude. The word processor in the computer represents a new reality.

Many other things at the AMA are computerized too. And some of the more esoteric things didn't exist 10 years ago, such as Fednet and Telemail. All of those things we bitch and complain about weren't there 10 years ago to bitch and complain about. So in a very real sense, they are in a new reality. The whole new reality, however, is that instant communication occurs — the ability to punch a button and bring up a whole new series of interested parties, in disparate places, and be able to communicate to them common problems, issues and solutions. It's an incredible opportunity. It's a new reality. Fednet today is less than three years old. It soon will have 100 subscribers.

Think about that in terms of your own activity. I suggest that by the end of the first quarter 1987, if every state, specialty and major county medical society in this country isn't on Fednet, they will be at a marked disadvantage when it comes to instant communication and the ability to interconnect. That's a new reality. I think it's one we can all anticipate.

That's exactly what we have to do — anticipate. We must anticipate change and not just react to it. The days in which we had the pleasure of just being able to sit back and react are gone. We do not have the luxury of sitting back and simply reacting. We may get tired of hearing about the revolution in health care. Everybody is fed up with it. Don't get fed up with it, because it's a fact. And the fact is that the revolution is occuring, and will continue to go on and on and on.

Fact of the matter is that since I graduated from medical school in 1951, 35 years ago, I have never seen changes come so fast, so big and so frequently. That is a reality, and over the last few years I have finally convinced myself that that reality isn't going to change. When I came to the AMA in 1974, it was the greatest, largest, sleepiest organization I think I ever saw. And remember I had been Chairman of the Board, and so it was a nice, pleasant, easy way to spend the day. You only had to make 15 to 20 decisions and you had eight hours to make them in. Today, we make more decisions before lunch than the Board of Directors of General Motors makes all year long, and that's a reality. And that reality doesn't change. It's just like us and our computers. Our employees had no choice, really, but to adapt to the computer. In my judgement they'll never have that choice again. I don't think that there's going to be a way that people can choose between old attitudes and new realities ever, ever again. We can't sit back in our office chairs and let the health care world roll by. If we do, I can identify a lot of people all around the country, including many in medicine, who'll be happy to step up and take that process over for us.

But there is some persistent notion that the only business in town is fee-for-service. I started out my professional life in 1952 in a little Texas town, Highlands — population 2,800. There were four doctors in town — two over age 70, my cousin Carl and me. Five years later, the older physicians were dead, and Carl was on his way through a series of eye operations into psychiatry. I was it. I was a fee-for-service doctor. I didn't have any choice; I was the only one there. And I did night duty and weekends and holidays and delivered babies on schoolhouse floors in the middle of Texas hurricanes. I didn't have any idea that someday I would be a minority as a fee-for-service doctor.

The new reality says that fee-for-service doctors are rapidly becoming a minority, and we have to understand that, because there isn't anything wrong with not being a fee-for-service doctor as long as you have control of your professional judgement. But the reality says that if you exclude all residents in this country, over 40% of everyone else in medicine today is in some kind of a group or under some sort of employment. And if you look at the numbers, they tell you that in very short order, that 40%-plus is going to be 50%-plus. The reality tells me that we as organized medicine have not taken that into account. We really have not come to grips with the fact, at any level in organized medicine in my opinion, that those numbers are rapidly changing.

We tried to come to grips with that when we had our first national symposium on employed physicians, and it reminded me of when we had our first national symposium of residents and medical students. It took so damn long to get there and there was no excuse for not being there sooner. We just didn't do it. And I suggest to you that everybody is guilty. We have simply not taken into account that the form in which medicine is delivered, the concept of the individual solo practitioner, whether or not the doctor has control of his professional judgment, is the sole determinate today of whether or not that individual is free to practice medicine as he knows how. And I think we have to be concerned about that.

If you look at the demographics of medicine today, half of all of the doctors in the United States, in fact slightly over half are under the age of 40. What an incredible difference from 1951 when I graduated from medical school. It seems to me that we have not yet come to the reality that the whole world of the federation is different.

From where I sit, I watch what you do, and this absolute nonsensical competition between counties and states, and between states and AMA, just absolutely staggers my imagination. We are a bunch of little children in the same household and we're gonna fight over the last cookie mama has on the plate. Why don't we stop that nonsense and decide that we're gonna help mama make a whole new set of cookies and put them on different plates. Instead I see counties fighting states, I see specialty societies fighting the AMA, I see states fighting the AMA. I hear specialty society people say, "We don't need the AMA. Specialty societies do all we need." I heard a man this morning say, "That ain't true. Specialty societies are an extension of academia. When you get beyond that, they don't do anything for their members." That's not true either, but there's a happy middle there someplace. It is the same old story — my car is better than your car, my daddy can beat your daddy up. Well, those same people are out there ready to splinter us even further if we just give them half a chance. It seems to me that we're giving them more than a half a chance.

I do not worry about the younger physicians. It is my age group that I'm worried about. These old fossils

have suddenly decided that everybody doesn't love them like they used to. Hell, I don't either. And they want us to correct their image. There is not a doctor in this country who would not profit by going to his nextdoor neighbor and saying, "Let me get on your extension telephone. I want you to call my office and make an appointment to see me, and I want to hear what my people say to you on the telephone." It is a fact — arrogant physicians hire arrogant office help. And you put those two together and you get an incredible reason to not go to doctors at all.

It seems to me that the other reality that we have not really given our full attention to is the reality of the demographic change in the American population. We talk about it a lot, we write a lot of articles about it. Everybody says they know old folks are the fastest growing segment, the over-85 is the fastest growing of that segment. All of that's true. But what have we done about that? Haven't done much about that. We don't seem to understand that it is a fact that the number of people who are 70 years old and older will double by the year 2000; that's 14 years away. And in the measure of time, 14 years is essentially nothing. We give a lot of lip service to that. We haven't done anything about it yet. We have not done anything about the fact that the number of people who will be 80 and over will triple by the year 2000. We don't do a damn thing about it. And the proof of that pudding is that we made no more progress in the last 10 years on the accreditation of nursing homes. But God loves them, somebody is going to take care of the old folks. I suggest to you that it is about time that we decided we are. We are their only advocates. If we live long enough, we're gonna get old. There is a degree of self-serving concern here about how it is that we are not taking care of the old people. And those are realities of life.

Put all of those together and you begin to look around to see what it is that you really are doing. We take great pride at the AMA that we crank out 32 million scientific journals a year; that's quite a feat. There are many loquacious doctors who like to write articles. My concern is the reality of what happens to the information after you have read it. I submit to you that not nearly enough happens.

We receive over 600 calls every day from radio stations around the country that are calling our American Medical Radio News, pre-taped messages of varying lengths. It is there for the asking. Take it, it is free. Use it. We have an incredibly wide variety of public service announcements for radio and television. We have everything from warning children not to get in a stranger's car all the way down to alcoholism for youngsters and adults. It is all there and it is free. And we send it out to television stations and they use it. I've traveled around the country, I've seen it on television stations again and again. Radio stations use it. Three million times every 24 hours in this country doctors interact with their patients. And you know what I was told this morning? That in the survey we are just now completing that deals both with the public and with physicians, the public does not recognize that we are giving them those messages. The recognition factor is less than 3%. The reality is that that way we are packaging the product does not carry with it a retention factor.

I hear a lot of conversation around the country about doctors being demeaned and having their roles reduced. I don't believe that at all. I have been in this profession for 35 years. I am just as convinced today as I was the day I walked across the stage in 1951 and got my degree, that any doctor who really cares, any doctor who really tries, is going to find patients who need help and want help. Between the two of them they can form the most magnificent joint venture in the history of man. And I don't care whether we have DRGs or PROs or anything else. There's absolutely nothing except physician apathy that keeps us today from being just as strong and just as powerful as we were in 1951. Just apathy; that's all.

I think there are some new realities out there. Think about it, and as you think of more new realities, write me and tell me. I'd like to hear from you as to what you think the new realities are. We won't need any help looking at old attitudes. Goodness knows, we've been looking at them for far too long. What we need is the guts to look at new realities.

James Sammons, M.D.
Chicago, IL

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We are number one but do not get excited

Emotion in motion is the state of mind for Florida physicians and spouses. We are angry and hostile that our state is number one in the nation in high rates for malpractice premiums and also in the total number of cases where awards in excess of one million dollars are handed down. Yet, we are hopeful that medicine will be healed.

Is it false hope? Not necessarily, contingent upon how much each of us is willing to help ourselves. Many things that are wrong with medicine have happened in Washington and Tallahassee and can be corrected through appropriate legislation. It is our duty to influence this legislation.

Rid yourself of excuses for not getting involved in the cure. Are you literate? Can you write letters or talk on the telephone? Do not say the doctor practices medicine and the wife cares for the home and children. What generates the income that makes it all fly?

Think of the sacrifices and dedication we all contribute to provide Floridians and others with the highest standard of medical care. Are they all in vain? Will the large majority in our ranks sit idle and expect a handful of interested medical families throughout the state work the politics for all the rest which has been the case for far too long? We must protect our investment or we deserve to be defeated.

The answer is obvious. Physicians are repairmen who have a God-given talent to fix broken minds and bodies. Patients seek them out to be healed. We must turn to our elected officials who can fix those aspects of medicine that have been broken in Washington and Tallahassee. If you have not figured this out you better wake up and smell the coffee.

Information on how to achieve this goal is available to every Florida physician and spouse whether actively involved in organized medicine or not. Are you a part of the solution or a part of the problem? The FMA Auxiliary is working diligently to be a part of the solution. To this cause we are dedicated.

Mrs. James H. (Nancy) Corwin II, M.Ed.
FMA-A Council on Legislation

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

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Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of lead author.

Abstract: All scientific manuscripts must include a 150 word, MAXIMUM LENGTH, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

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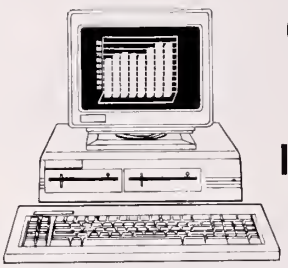
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APRIL

Issues and Advances in Pediatrics 1987, April 2-4, Sheraton Sand Key Resort, Clearwater Beach. Contact: L.A. Barness, M.D., (813) 974-4214.

Coronary Heart Disease, April 3-4, Marco Beach Resort, Marco Island. Contact: Deborah Wilderson, (303) 798-9682.

Pediatric Oriented ACLS Provider Course, April 3-5, USF College of Medicine, Tampa. Contact: James V. Hillman, M.D., P.O. Box 18566, Tampa 33679, (813) 251-6911.

Medical Staff Issues and the Changing Hospital Environment, April 3-5, Sonesta Beach Hotel, Key Biscayne. Contact: Steve Moldaver, 8245 N.W. 53rd St., Miami 33166, (305) 591-8020.

Practical Aspects of Newer Cardiovascular and Renal Therapies, April 5-8, Orlando. Contact: Division of CME (D23-3), University of Miami, (305) 547-6716.

Imaging at the Masters, April 5-10, Pine Isle Resort, Pine Isle, GA. For more infor: Lawrence Muroff, M.D., (813) 873-2090.

Interdisciplinary Rape Science Institute, April 5-10, Miami. Contact: University of Miami, Division of CME (D23-3), (305) 547-6716.

Annual Temporal Bone Course, April 6-10, USF College of Medicine, Tampa. Contact: Loren Bartels, M.D., (813) 974-2411.

Sports Medicine and Office Orthopedics, April 6-10, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

Tutorial Course in Acute Cardiac Care for the Practicing Physician, April 6-11, University of Miami, Division of CME (D23-3), University of Miami, (305) 547-6716.

Issues in Prenatal Care — 1987, April 10-11, Indigo Lakes, Daytona Beach. Contact: Carl Schwenker, M.D., 650 N. Clyde Morris Blvd., Daytona Beach 32014, (904) 252-4701.

Medical Risk Management, April 11, 1987, West Palm Beach. Contact: Victor Martinez, M.D., (813) 870-3633.

Advances in Magnetic Resonance Imaging, April 13-16, Palace Hotel, Orlando. Contact: Charleen Krissman, (813) 974-2538.

Coping With Stress and Anxiety, April 13-17, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

Spring 1987 Family Practice Review, April 13-17, Sheraton World, Orlando. Contact William L. Stewart, M.D., (904) 392-4321.

Silent Myocardial Ischemia, April 16, Oak Hill Hospital, Brooksville. Contact: Richard Trump, (904) 799-0135.

1987 Update on Diseases and Imaging of the Spine, April 17-18, Palace Hotel, Orlando. Contact: Charleen Krissman, (813) 974-2538.

Otolaryngology in Family Practice, April 17-18, USF College of Nursing, Tampa. Contact: James N. Endicott, M.D., 13000 N. 30th Street, Tampa 33612, (813) 972-7585.

Outpatient Gynecology, April 20-24, Marco Island Resort, Marco Island. Contact: Albert Finestone, M.D., (215) 221-4787.

Second Congress on Sports Injuries for the Primary Care Physician, April 23-25, Village of Grenclefe, Grenelife, FL. Contact: Brian C. Halpern, M.D., (904) 324-6661.

1987 Radiation Therapy Clinical Research Seminar, April 23-25, University Centre Hotel, Gainesville. Contact: Timothy A. Brant, M.D., Radiation Therapy Division, University of Florida, JHMHC J-385, Gainesville 32610, (904) 395-0287.

Management of Type II Diabetes, April 24-25, Safety Harbor Spa, Safety Harbor. Contact: Anthony Morrison, M.D., (813) 974-4360.

Tachys, Taxes and Blocks, April 24-16, Sheraton Sand Key Hotel, Clearwater Beach. Contact: Henry Marriott, M.D., 601 12th Street, North, St. Petersburg 33705, (813) 894-0790.

Geriatrics — Anesthesia Risks, April 24-26, Holiday Inn, Pensacola Beach. Contact: Warren W. Sears, M.D., (904) 434-4718.

Miami Comprehensive Review Course in Anesthesiology, April 25-May 2, Key Biscayne. For more information: University of Miami, Division of CME (D23-3), (305) 547-6716.

Clinical Virology Seminar, April 26-29, Holiday Inn Surfside, Clearwater. Contact: Steven Specter, M.D., (813) 974-3281.

Overview of Diabetes, April 27, 1987, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

MAY

Chest Pain 1987, May 1-2, New World Landing, Pensacola. Contact: (904) 434-1093.

Radiology Review Course, May 3-8, Sheraton Bal Harbour, Miami. Contact: Lucy R. Kelley, (305) 674-2681.

Comprehensive Review and Update in Emergency Medicine, May 4-8, Hyatt Regency Westshore, Tampa. Contact: Eilleen Weimerskirch, M.D., (214) 550-0911.

ACLS Instructors Course, May 8-10, St. Augustine Technical Center, St. Augustine. Contact: Mrs. Margo Kinsey, St. Augustine Technical Center, St. Augustine 32084, (904) 824-4401.

Five-day Management of Diabetes Mellitus, May 11-15, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

Pediatrics for the Practitoner — Update on Learning Disabilities, May 15, Bay Harbor Inn, Tampa. For more information: Herbert Pomerance, M.D., 813-974-4214.

Review Course for Certification in Internal Medicine, May 17-22, Key Biscayne Hotel, Key Biscayne. Contact: University of Miami, Dept. of CME, (305) 547-6716.

Magnetic Resonance Imaging, May 18-22, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Mock Trial, May 23, West Florida Regional Medical Center, Pensacola. Contact: Margie Rickell, (904) 478-4460.

Practical Applications in Internal and Emergency Medicine, May 25-29, Marco Island Resort, Marco Island. Contact: Albert J. Finestone, M.D., (215) 221-4787.

Master Approach to Cardiovascular Problems, May 30-June 1, Contemporary Hotel, Lake Buena Vista. Contact: Agustin Castellanos, M.D., (305) 549-7124.

JUNE

Family Practice '87, June 8-11, Hilton Hotel, Orlando. Contact: Thomas Stewart, M.D., (912) 452-2213.

Contemporary Issues in Medicine, June 12-14, Amelia Island Plantation, Amelia Island. Contact: Jeanette Stone, 1-800-423-4492.

Diagnosis and Management of Respiratory Disease, June 19-21, Dutch American Hotel, Orlando. Contact: Deborah Wilderson, (303) 798-9682.

Two-Dimensional Echocardiography, June 22-26, Orlando. Contact: American College of Cardiology, (800) 253-4636.

Ninth Annual Cuban Medical Association Congress, June 28-July 5, Sheraton Bal Harbour, Bal Harbour. Contact: M. Viamonte Jr., M.D., (305) 674-2680.

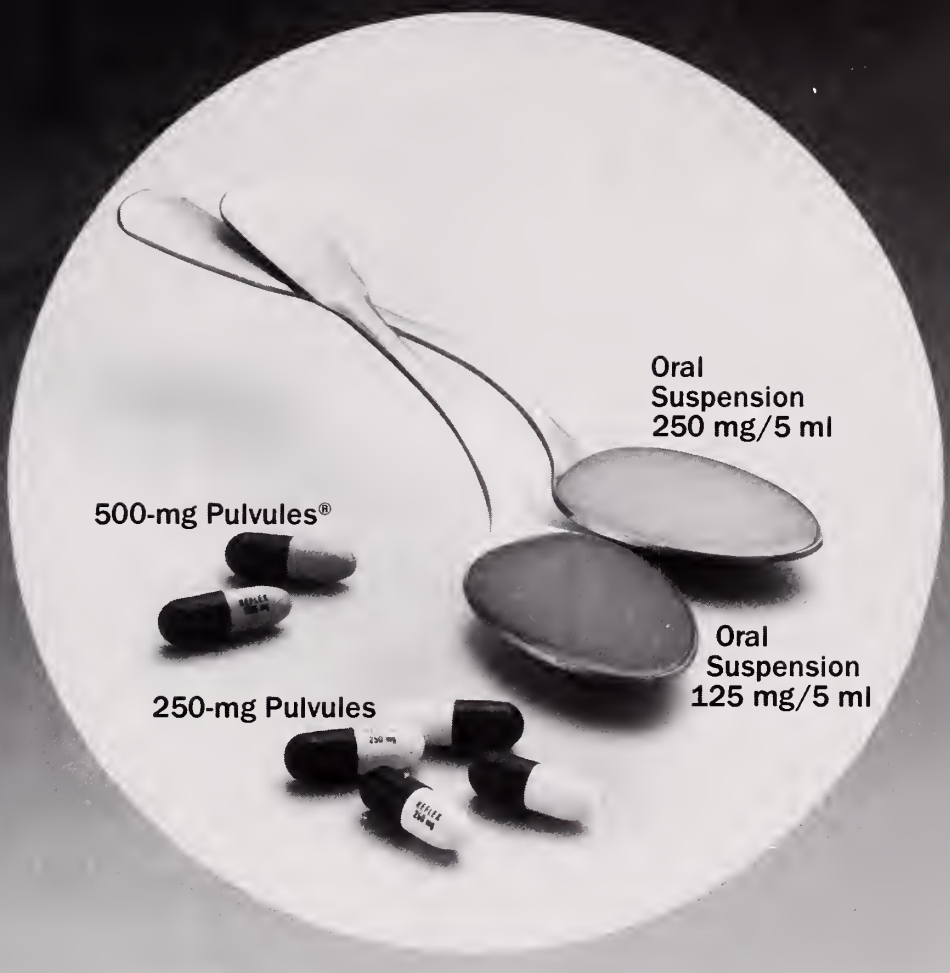
JULY

1987 Clinical Conference on Pre-Hospital Emergency Care, July 9-12, Orlando Hyatt, Kissimmee. Contact: Registrar, (305) 628-4800.

AUGUST

Coronary Heart Disease, August 14-15, Orlando Hyatt Hotel, Orlando. Contact: Deborah Wilderson, (303) 798-9682.

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Please see brief summary of Glucotrol® (glipizide) prescribing information on next page.

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1. Sachs R, Frank M, Fishman SK: Overview of clinical experience with glipizide. In *Glipizide: A Worldwide Review*. Princeton, NJ, Excerpta Medica, 1984, pp 163-172

GLUCOTROL® (glipizide) Tablets
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INDICATIONS AND USAGE: GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate trial of dietary therapy has proved unsatisfactory.

CONTRAINDICATIONS: GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin.

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY: The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes*, 19, supp. 2:747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2-1/2 times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy.

Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

PRECAUTIONS: Renal and Hepatic Disease: The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function. Hypoglycemia may be prolonged in such patients should it occur.

Hypoglycemia: All sulfonylureas are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemia. Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions. Elderly, debilitated or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

Loss of Control of Blood Glucose: A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery. It may then be necessary to discontinue GLUCOTROL and administer insulin.

Laboratory Tests: Blood and urine glucose should be monitored periodically. Measurement of glycosylated hemoglobin may be useful.

Information for Patients: Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and/or blood glucose. The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members. Primary and secondary failure should also be explained.

Drug Interactions: The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including nonsteroidal anti-inflammatory agents and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta adrenergic blocking agents. *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicumarol. However, caution must be exercised in extrapolating these findings to a clinical situation. Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid. A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported. Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known.

Carcinogenesis, Mutagenesis, Impairment of Fertility: A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity. Bacterial and *in vivo* mutagenicity tests were uniformly negative. Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility.

Pregnancy: Pregnancy Category C. GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide. The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL. In studies in rats and rabbits no teratogenic effects were found. There are no adequate and well controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible.

Nonteratogenic Effects: Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery. This has been reported more frequently with the use of agents with prolonged half-lives. GLUCOTROL should be discontinued at least one month before the expected delivery date.

Nursing Mothers: Since some sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: In controlled studies, the frequency of serious adverse reactions reported was very low. Of 702 patients, 11.8% reported adverse reactions and in only 1.5% was GLUCOTROL discontinued.

Hypoglycemia: See PRECAUTIONS and OVERDOSAGE sections.

Gastrointestinal: Gastrointestinal disturbances, the most common, were reported with the following approximate incidence: nausea and diarrhea, one in 70; constipation and gastralgia, one in 100. They appear to be dose-related and may disappear on division or reduction of dosage. Chloestatic jaundice may occur rarely with sulfonylureas. GLUCOTROL should be discontinued if this occurs.

Dermatologic: Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria, pruritus, and eczema have been reported in about one in 70 patients. These may be transient and may disappear despite continued use of GLUCOTROL; if skin reactions persist, the drug should be discontinued. Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, and pancytopenia have been reported with sulfonylureas.

Metabolic: Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas. Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions.

Endocrine Reactions: Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) secretion have been reported with this and other sulfonylureas.

Miscellaneous: Dizziness, drowsiness, and headache have been reported in about one in fifty patients treated with GLUCOTROL. They are usually transient and seldom require discontinuance of therapy.

OVERDOSAGE: Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia. If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL. Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery. Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease. Because of the extensive protein binding of GLUCOTROL (glipizide), dialysis is unlikely to be of benefit.

DOSAGE AND ADMINISTRATION: There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL; in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia.

Initial Dose: The recommended starting dose is 5 mg before breakfast. Geriatric patients or those with liver disease may be started on 2.5 mg. Dosage adjustments should ordinarily be in increments of 2.5-5 mg, as determined by blood glucose response. At least several days should elapse between titration steps.

Maximum Dose: The maximum recommended total daily dose is 40 mg.

Maintenance: Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing. Total daily doses above 15 mg should ordinarily be divided.

HOW SUPPLIED: GLUCOTROL is available as white, dye-free, scored diamond-shaped tablets imprinted as follows: 5 mg tablet—Pfizer 411 (NDC 5 mg 0049-4110-66) Bottles of 100; 10 mg tablet—Pfizer 412 (NOC 10 mg 0049-4120-65) Bottles of 100.

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240 mg scored, sustained-release tablets



JAMES B.
38, black male, heavy smoker. Prescribed a diuretic by another physician last year for hypertension.

YOUR CONCERNS
Presents with "smoker's cough." Workup reveals a BP of 150/107.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN® (verapamil HCl/Knoll) because...
— Black hypertensives often have low plasma renin activity and generally do not respond favorably to beta blockers.
— Beta blockers may increase the likelihood of bronchospasm.

ALICE W.
65, diabetic, overweight. Her BP has elevated to 190/98.

YOUR CONCERNS
She's on daily insulin.

A LOGICAL CHOICE FOR CONTROL OF HER BP
ISOPTIN® (verapamil HCl/Knoll) because...
— Unlike most beta blockers and diuretics, ISOPTIN has no adverse effects on serum glucose levels.
— Unlike most beta blockers, ISOPTIN does not mask the symptoms of hypoglycemia.





THOMAS G.
70, asthmatic. In the past, BP adequately controlled with 25 mg hydrochlorothiazide daily.

YOUR CONCERNS
Today patient presents with symptoms of gout. Workup reveals high uric acid level, low serum potassium, and BP elevated to 180/98.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN® (verapamil HCl/Knoll) because...
— Unlike diuretics, ISOPTIN will not decrease serum potassium levels or elevate uric acid levels.
— Unlike beta blockers, ISOPTIN can be used safely in asthma and COPD patients.

JOHN K.
42, Annual physical uncovered diastolic BP of 102... confirmed on three successive office visits. Unresponsive to nonpharmacologic intervention.

YOUR CONCERNS
Salesman, spends many hours of his working day in car... total cholesterol level 300, HDL 35.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN® (verapamil HCl/Knoll) because...
— Unlike diuretics, ISOPTIN does not cause urinary urgency.
— Unlike either beta blockers or diuretics, ISOPTIN will not adversely affect his already seriously compromised lipid profile.
— Unlike with propranolol, fatigue and impotence are rarely reported.



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Brief Summary

ISOPTIN® SR
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CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: Heart Failure: ISDPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIDNS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. Hypotension: ISDPTIN (verapamil HCl) may produce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. Accessory Bypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see DVERDDSAGE).

Drug Interactions: Beta Blockers: Concomitant use of ISDPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. Digitalis: Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISDPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. Disopyramide: Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. Quinidine: In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy. Nitrates: The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. Cimetidine: Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carbamazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may markedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in patient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISDPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. Pediatric Use: Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

AOVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, edema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 3° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, dyspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, insomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, syncope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVERDOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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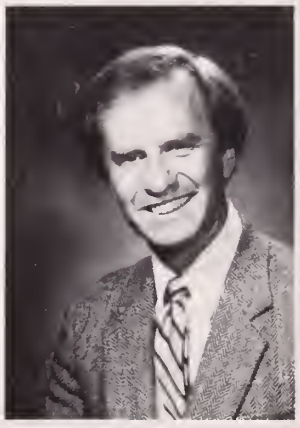
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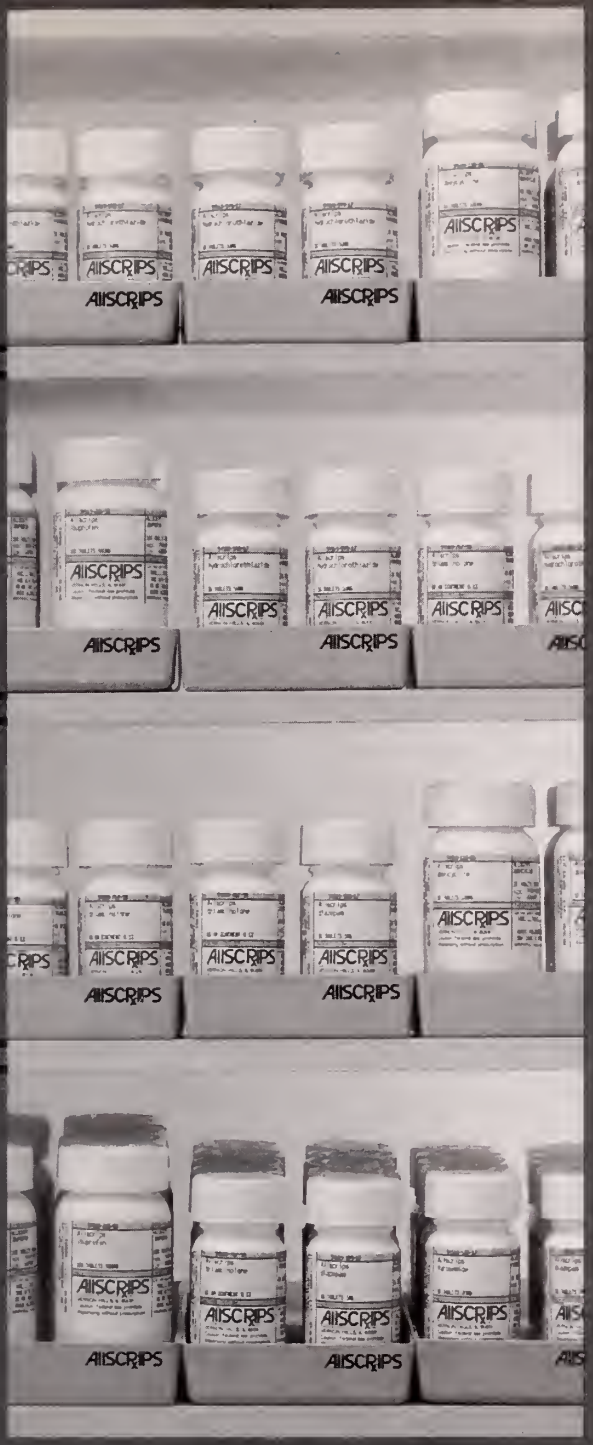
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Interdependence needed to solve problems



Dr. Perry

In the course of assessing the travails that beset organized medicine, one cannot help but realize the problems are not limited to physicians but are indigenous to all society. Many are aware of this, and we have seen numerous coalitions formed to help alleviate the difficulties that beset a specific aspect of the society or group that they represent.

We have seen advertisements in the *Wall Street Journal* paid for by Aetna Insurance and their promise of the golden rule is very hard to argue against. They and other insurance companies are in business to make a profit, pool resources and premiums, resolve issues, and most of all provide the protection which all of us need. I hope that those who buy this needed protection, as responsible members of this society, do it not only for their own economic and social welfare, but also realize and recognize that the interdependence is for the common good. This is obvious in the family and with friends locally, or spread apart by distance or even schism. It goes beyond families and operates in local clans or communities, counties, states, nations, hemispheres, and even probably worlds.

There is an old axiom that if it works, don't fix it, and it could never be more important. The problem is that the insurance system isn't working, at least in the liability area, and it needs fixing. Those with vested interests in the current system yell and scream, "don't tamper with the tort system;" yet, even knowing it isn't working and having purportedly the expertise to help correct it, refuse to become involved. They point fingers at bad doctors, bad insurance companies, and other bad things about which they know little or nothing. It is all too obvious they are alienating themselves and their system from our society which is a government of, by, and for the people. Sooner or later, that same government needs to quit turning the deaf ear and listen to its constituents.

Interdependence was vividly exemplified in three recent incidents, all pointing in the same general direction.

While skiing on Vail Mountain, a friend of mine and I cut off to ski "steeper and deeper." My wife hesitated, wanted to go with the men, but elected to ski with her slower and more inactive friend. That friend, after resting a moment and talking, suddenly collapsed with an acute respiratory arrest. A local ear, nose and throat physician happened by and began CPR. The ski patrol called, "pull out all stops," and within three minutes literally dozens of trained people converged, stabilized, and then transported the stricken lady to a nearby hospital.

The etiology and treatment are not the important factors. The help, support, and interdependence of several segments of society without hesitancy or guile and with a great deal of expertise are what saved a life. There was no thought about payment, insurance, or litigation.

A few days earlier, a very poignant story unfolded a half continent away. A legislator, a pharmacist, and representatives of the Florida Medical Association met. The meeting was called to address the problem of a serious incursion into the procurement and distribution of drugs by independent practicing physician groups. Perhaps this is in retaliation to ill-advised legislation passed in 1986 that allows pharmacists to prescribe medications from a predetermined formulary. It conversely makes continuing medical education in pharmaceuticals a must for physicians who dispense drugs in their offices. On the surface, perhaps both are desirable.

There is, however, by the thesis and antithesis, a fallout that adversely affects pharmacists, physicians, and patient interdependence; that is, the adversarial relationship and the exclusion of the independent pharmacists as a viable business in this country today. This is not a healthy atmosphere. People need them for

referrals, for consultations, and for friendship not always present in big chain stores. The pharmacists need to survive but they are also needed as a link in the health care system that should remain viable and effective. We need them and they need the members of the entire health care provider team for a strong and compatible interdependent relationship.

The third and perhaps most important incident occurred at the American Medical Association Leadership Conference in Chicago, a subsequent Florida Medical Association Board of Governors' meeting in Jacksonville, and a press conference in Miami. The American Medical Association, its Board and Legal Council, have intervened in the Health Care Access crisis and are helping as much as humanly possible to alleviate the problem in Florida as well as other key states. Their efforts are applauded and underscore our mutual interdependence. This was also reemphasized at the Association of Medical Society Executives meeting in Chicago the second week of March.

The difficulties that the people of Florida have had in addressing the professional liability crisis and the resulting health care access crisis have led to a recognition of the severity of this societal problem by national and international leaders in government, insurance and economics. Re-insurance is severely curtailed. Legislation, despite its well-intended tenets addressed for 13 years and the interpretation of these laws by courts, has solved nothing. The crisis is more serious than ever and affects more and more people. It is not just professional liability that we are primarily concerned about but all liability including products, homes, businesses, automobiles, and even toys and hobbies.

The American Medical Association has realized that, as the parent organization potentially able to bring major efforts to influence all segments of society, it has the responsibility to encourage the lawmaking bodies as well as the courts to address the issue for a permanent solution. This solution cannot be just another porous, band-aid, window-dressing approach so prevalent in the past. Part of the difficulty is the control by committees in Congress and also the individual states by five or six individuals, usually with self-serving interests in "not changing the system." It is, regardless of whatever is agreed, a very lucrative economic issue. Society has often reflected upon its own self-interests with "its rights" with finger pointing, and the "why not get the devil's philosophy." Perhaps it is waking up to the fact that this parochial mentality has hurt the very people who would like to believe that they benefit from the results of the tort system largess.

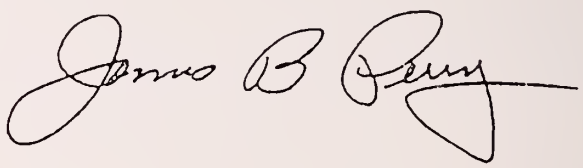
For an eventual solution to this debacle, we as an organization, or as individuals in and outside of that body, realize the need and dependence upon one another. As physicians, we need to appreciate and respect our friends and our relationships to those friends. Specific examples are the emergency medical service and paramedical support teams involved in the previously mentioned incident. The pharmacists also are deserving of our respect and thanks.

More than ever, there are certain individuals in the American Medical Association, notably James H. Sammons, James S. Todd, William S. Hotchkiss, John J. Coury Jr. and legal counsel, Kirk B. Johnson, the full Board of Trustees, and our own representative to that Board from Florida, Rufus K. Broadaway, without whom the Board cannot function and deserve our support and thanks.

It does not stop there. Our interdependence upon all members of society in our way of life and our work has to be considered daily. This is especially true in our work place with the nurses and paramedical personnel and secretaries in our hospitals and offices.

Without the help of these and others from organized medicine, as well as all of our personal friends, we cannot hope to progress and go forward. There are good signs and the barometer is rising. Friends and colleagues, we shall prevail with God's help because our cause is just and right.

Have you all joined or are you among those who sit and wait?



ROCHE

BECAUSE ONLY VALIUM



IS ALWAYS VALIUM®

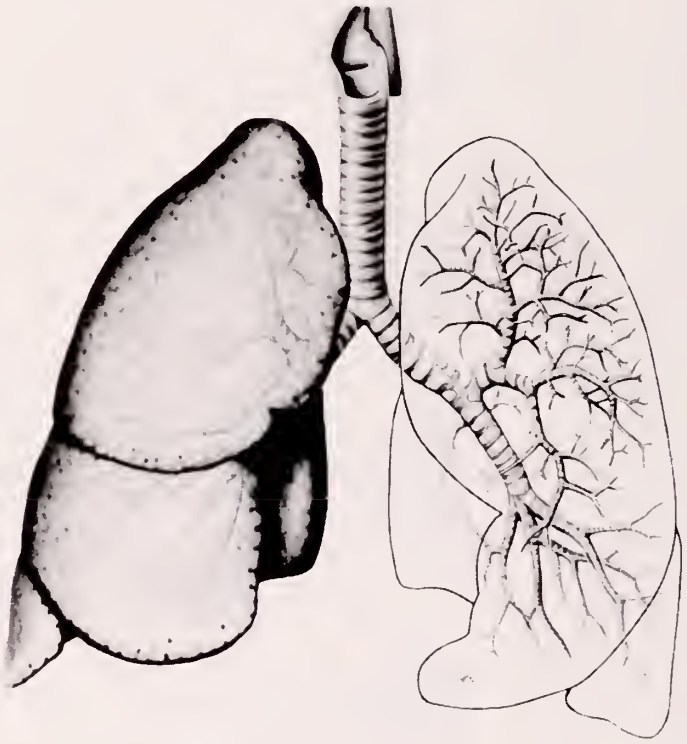
brand of diazepam/Roche ℞

REMEMBER TO WRITE "DO NOT SUBSTITUTE."
IT'S THE ONE YOU KNOW BEST.

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Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary Consult the package literature for prescribing information

Indications and Usage Ceclor® (cefaclor Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindications Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS (INCLUDING ANAPHYLAXIS) TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions *General Precautions* — If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when anti-globulin tests are performed on the minor side or in Coombs' testing of neonates whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours, respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and frequently fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis, occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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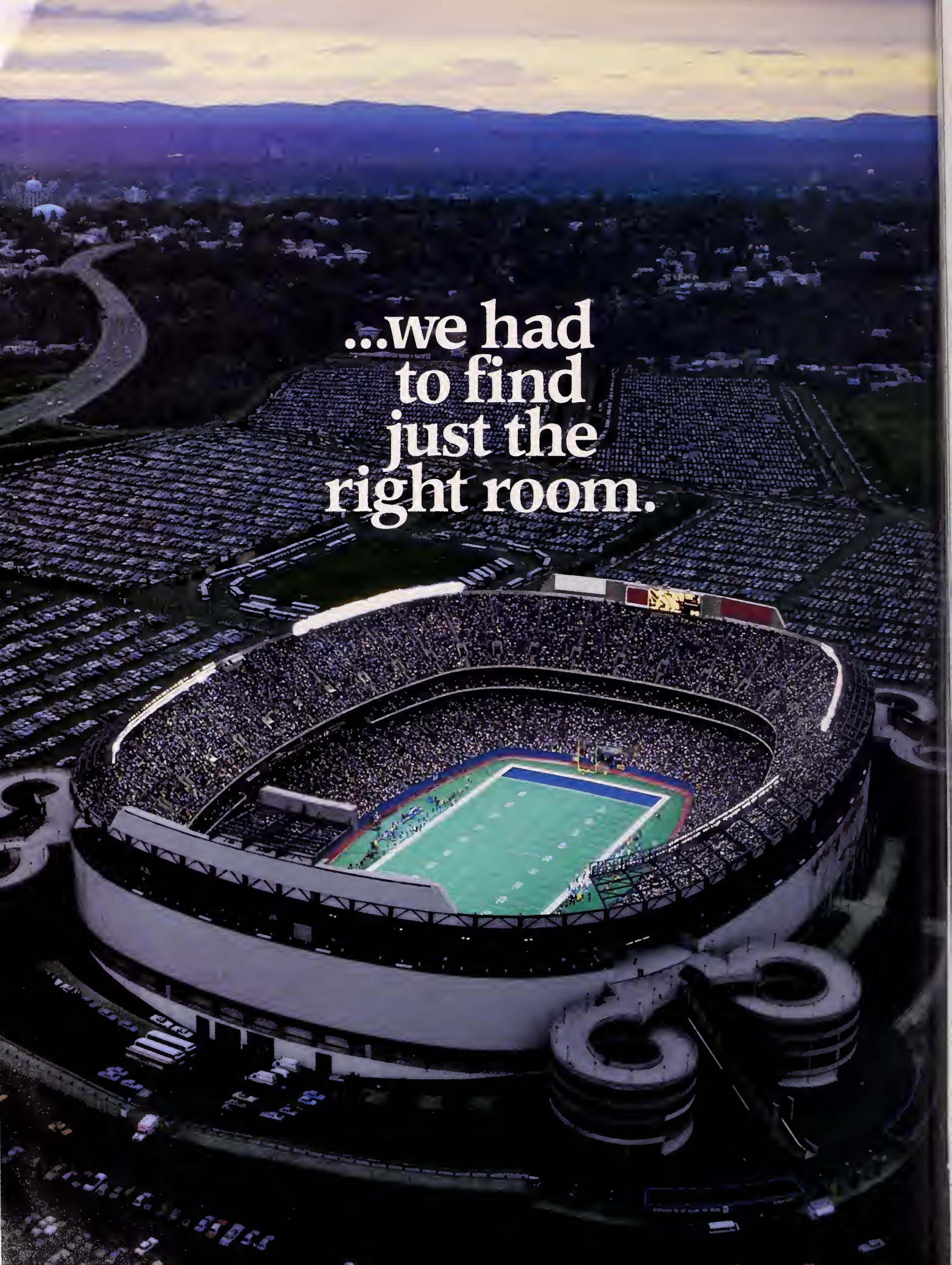
Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Lilly

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

To show you how many hypertensives stayed on INDERAL® LA (PROPRANOLOL HCl) after a major nationwide trial...




...we had
to find
just the
right room.

60,073 patients (90%) who started on INDERAL® LA stayed on INDERAL LA.[1*]

Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.
A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.

Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were controlled merely with the addition of a diuretic to INDERAL LA.

For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

Control, comfort, and compliance

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.



INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) – PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency usually of the Raynaud type.

Central Nervous System. lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. bronchospasm.

Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION – *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS – *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE – *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS – 80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE – At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

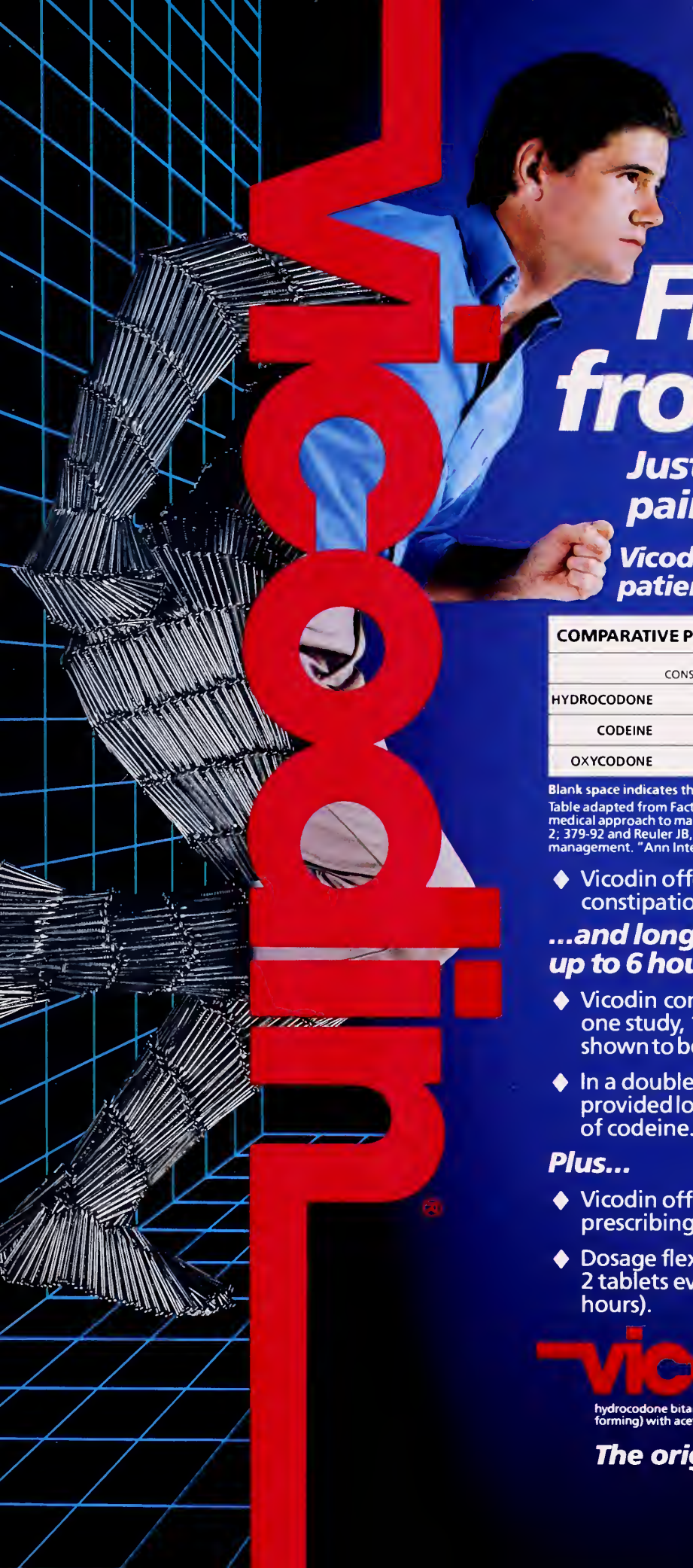
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1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321-1323.

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New York, NY 10017

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Freedom from pain

Just one part of pain relief therapy.

Vicodin® provides greater patient acceptance

COMPARATIVE PHARMACOLOGY OF THREE ANALGESICS

	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

- Vicodin offers: less nausea, less sedation, less constipation.

...and longer lasting pain relief– up to 6 hours.

- Vicodin contains hydrocodone not codeine. In one study, 10 mg. of hydrocodone alone was shown to be as effective as 60 mg. of codeine.[1]
- In a double-blind study, Vicodin (2 tablets), provided longer lasting pain relief than 60 mg. of codeine.[2]

Plus...

- Vicodin offers the convenience of CIII prescribing.
- Dosage flexibility–1 tablet every 6 hours or 2 tablets every 6 hours (up to 8 tablets in 24 hours).

Vicodin®

hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.

The original hydrocodone analgesic.

Specify "Dispense as written" for the original hydrocodone analgesic.

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. 5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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Doing less and thinking more or How to save more and order less

Reasoned judgment rather than routine testing and less rather than more may come back as emblems of medical practice in the next few years.

The historic joint announcement on April 2 by Blue Cross-Blue Shield and the American College of Physicians of guidelines for the appropriate use of the 15 most common diagnostic tests, hailed by consumer groups and various medical organizations, is certain to change the ways that physicians practice. While the concept of doing less and avoiding the routine is nothing new, the guidelines eventually will be used to deny reimbursements to physicians where testing is found inappropriate. This may sound like a draconian measure, but it should not necessarily be so.

Physicians should applaud this move by the Blues and the ACP. It is a sensible if belated call for physicians to go back to the basics, to exercise good clinical judgment, and to rely less on technology in taking care of their patients. Furthermore, at a time when the costs of medical care keep soaring, the practice of doing only what is necessary will save patients billions of dollars yearly.

Although we have always valued clinical judgment in the practice of medicine, its use has been blunted somewhat by developments that have forced physicians to alter their practice patterns. One of these is the advent of technological advances; another is the escalation of the malpractice crisis. A third, rarely mentioned, is the profit-making potential to physicians of increased diagnostic testing.

The development of technology capable of doing multiphasic testing in large numbers of patients has been a boon to hospitals, laboratories, and even doctors' offices. Tests that previously required hours and even days can now be performed at the touch of a button, with results out in a few minutes. This capability theoretically should reduce the costs to patients, and in many instances it has. But many hospitals, laboratories, and physicians are still charging patients far above what it costs them to do the testing. It is not unusual, for example, for hospitals to charge more than $100 for a CBC, urinalysis, and chemistry profile when the same combination is being offered for $10 or less by commercial laboratories. In addition, the easy availability in physicians' offices of diagnostic equipment has led to the indiscriminate and excessive use of testing even for marginal indications. The routine use of chest x-rays, EKGs, and laboratory tests in healthy patients has not been found beneficial.

The malpractice problem, on the other hand, has given rise to the practice of what is euphemistically called defensive medicine. A substantial number of lawsuits filed against physicians have been triggered by "missed diagnoses," hence, the propensity to do everything possible. Every headache deserves a CT scan, every chest pain an EKG, every cough a chest x-ray, and every ache and pain a full complement of laboratory tests. The fallacy of this indiscriminate testing is that it protects physicians more than it benefits the patients. Physicians, not lawyers, should set standards for medical practice and should be able to decide what to do and what not to do according to their best medical judgment. They must not be obliged to do more than what is necessary and reasonable.

Still another reason goading some physicians to push for increased diagnostic testing is that it can be a profitable business. Physicians who own laboratories and those who have installed a panoply of diagnostic paraphernalia in their offices know that the monetary rewards are there. The technical and professional fees involved in such testing can add up to a hefty bundle year after year. Those who have not equipped their offices with these frills and gimmicks, as they are commonly called in the trade, are constantly courted by sweet-talking salesmen whose gaudy brochures and pitches often tout the extra profits to be made from these ventures. While most physicians are honest, and while there is nothing wrong per se in doing diagnostic testing in the office, the temptation to

overdo them is strong because of the profit motive. Nobody, after all, looks over physicians' shoulders and most insurance companies are only too willing to reimburse everything without question. Most of the abuses we read so much about will be gone if we eliminate the profit motive.

The plan by the Blues to start monitoring physicians' practices and eventually to deny payment for inappropriate testing is obviously aimed at reducing medical costs. Every year it costs patients $27 billion for the 13 most commonly used laboratory tests, $2 billion for chest x-rays, and $1 billion for EKGs. Physicians ought not to complain about being asked to be prudent as long as they are able to practice their profession untrammeled by arbitrary regulations. The Blues' plan certainly is not an unreasonable regulation.

What all this boils down to is that the common, almost mindless practice of ordering an array of tests in many clinical situations will have to stop. Preoperative testing, annual physical examinations, and certain screening examinations will have to be modified to reflect current thinking and to reject what has previously been established as gospel without any sound reason. Reducing the number of diagnostic tests will hurt the pockets of hospitals, laboratories, and even a few physicians. But it is time to do away with the excesses and abuses of the past.

Prestigious organizations like the AMA and groups of internists, radiologists, pediatricians, anesthesiologists, and obstetrician-gynecologists are solidly backing the plan of Blue Cross and Blue Shield. It is an opportunity for physicians to show that they are concerned about cutting the costs of medical care. Only the American College of Pathologists has objected so far. But with the backing of AMA, specialty groups and most primary care practitioners, Blue Cross and Blue Shield appear certain to get the program going a year from now, hoping to spend the first year orienting and educating physicians on the proposed guidelines.

Physicians ought to go one step further and propose that similar guidelines be extended to less frequently ordered but more expensive tests and procedures. We ought to eliminate all kinds of waste, discard outworn and shoddy thinking habits, and return to the tradition of common sense, good clinical judgement, and an unflagging dedication to the interests of our patients.

R.G. Lacsamana, M.D.
Editor

Is medicine a rewarding career?

Although there may be less economic and clinical freedom for physicians in the future medical marketplace, that does not mean gloom and doom for the profession or the candidates who enter it. The best members of our profession do not seek limitless wealth or power, they seek work which will benefit society. Yet increased debt loads, increased costs to establish a practice and increased competition negatively influence bright young students who could choose medicine from a wide variety of lucrative fields.

In a profession fragmented by the diverse problems of its many specialties, whose members are asked to quantify quality by identifying the bad apples among us, we are exposed to a national epidemic of anxiety. Faced with a growing body of sophisticated technology and important information, we are forced to contain costs in using those advances. If, in this epidemic amongst our profession, anxiety is all that is treated, we will only be treating the symptoms and not the disease. To regain position of prominence, a sense of professional ethics and responsibility to patients we must assume ascendency over a business and profit-motivated mentality, which in the last two decades has influenced us to allow our former ideals to be subverted.

It is up to medical educators to be in the forefront of change, training the right number of people in the right way by developing programs that promote growth, innovation and lifelong learning. New insights are needed to determine how best to teach the substantial volume of knowledge in a medical environment that in the future may be more restricted economically and clinically. The work may be less lucrative, but it is up to all dedicated supporters of organized medicine to hold fast to age-old values that have made American medicine the world standard, to unite to assure quality through essential control systems, to remain sensitive to the needs and wants of patients, to work with and around the outside economic and government forces adversely influencing us from using technology appropriately and with caring. If we so respond, the members of our profession can still aspire to a career which is among the most rewarding possible — personally, socially, scientifically and economically.

Clyde M. Collins, M.D.
Contributing Editor
Jacksonville

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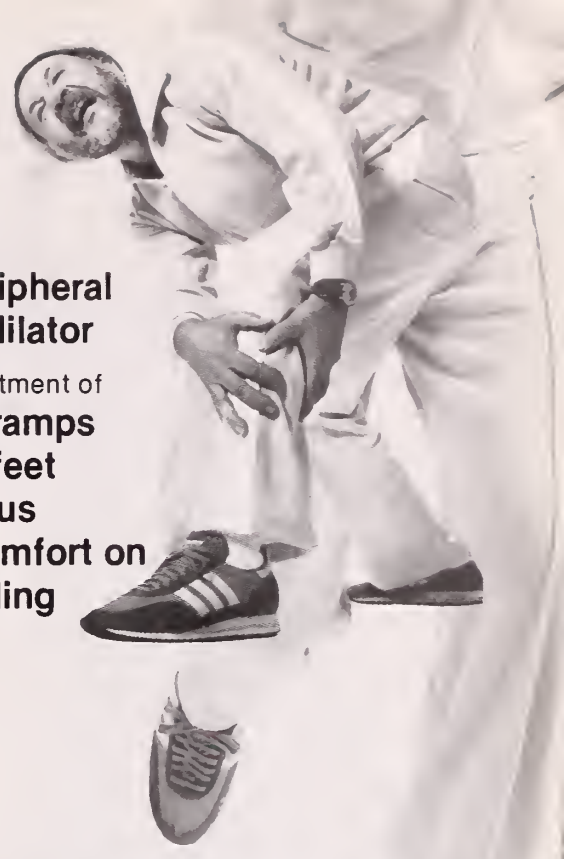
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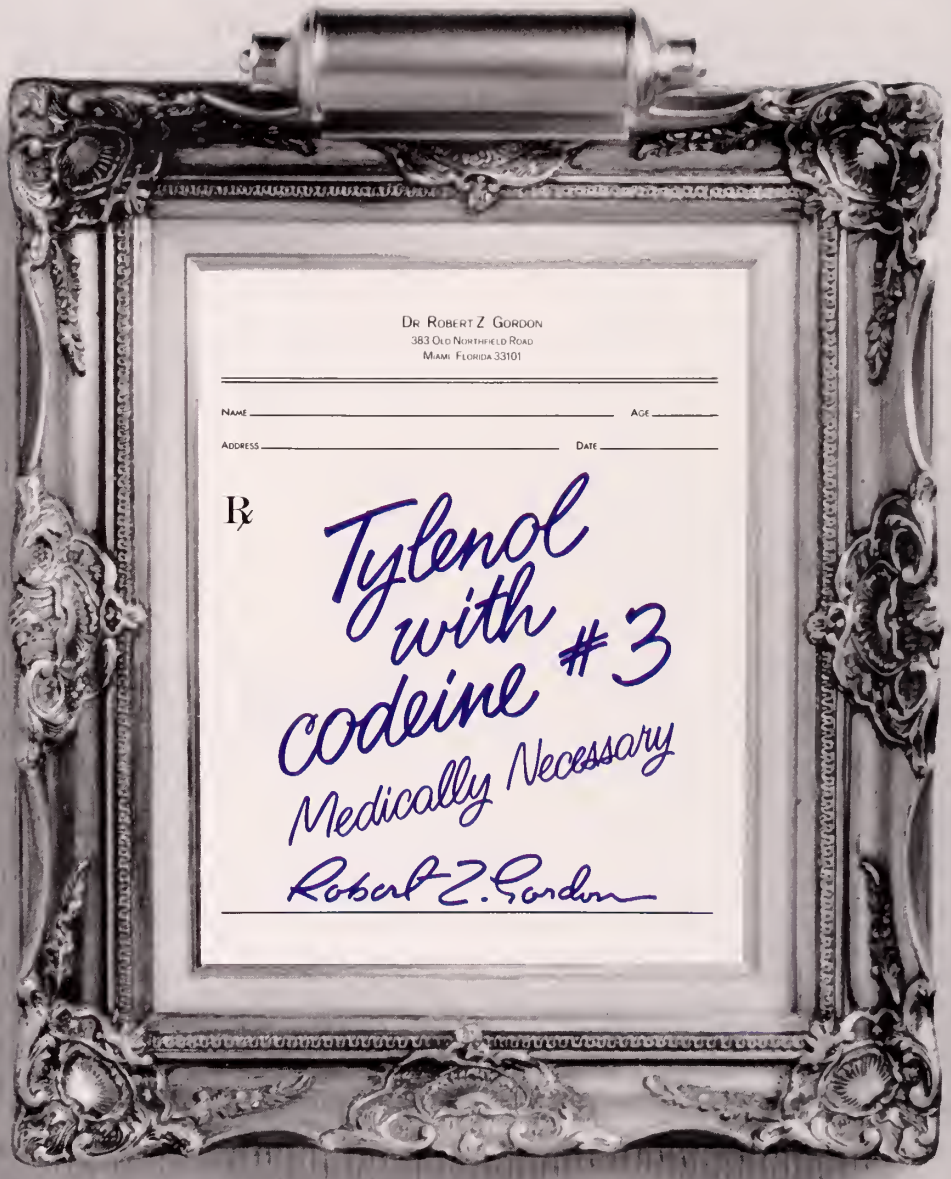
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Restoring altruism will solve the indigent care problem

After going through the February, 1987 issue of *The Journal* ("Indigent Health Care") I was wondering whether the juxtaposition of the FMA auxiliary column, "Interplast South Brightens the Childs Future," was intentionally incorporated in this issue or if its ironic presentation was simply coincidental.

I found it interesting that 65% of all physicians in Florida refuse to accept Medicaid patients (and undoubtedly a larger number are refusing to accept patients without any medical insurance), that a small group of physicians would travel to a foreign country and over a period of 8 days to see 200 patients and perform 100 reconstructive plastic surgery procedures. I am sure that if every physician in the State of Florida took the personal time and effort and sacrifice 8 days, there certainly would be no indigent medical care problem and no longer be 1.9 million "medically needy" people in our state. The FMA Auxiliary Leadership Conference could continue its activities with the sale of items "such as plastic nonspillable mugs, FMA-A logo umbrellas and an opportunity for a Pot of Gold" to help fund services that our Florida physicians may not be able to provide and would require sending our Florida residents to other states.

Yes, irony has a unique way of showing a problem that was not addressed in your 154-page special issue. That problem is one of individual motivation to do things. While 4.3 million of our 12 million population has an annual income less that 150% of the poverty level, the overwhelming majority of the physicians in the state are in the top 1% income levels. While I am not suggesting that all medical care should be provided without concern of remuneration (just as a grocery store cannot be expected to provide free food and a hotel cannot be expected to provide free lodging for a homeless person) I think that you will agree that physicians in our state can potentially re-evaluate their personal motivations. Is a poor young child without insurance who presents to an emergency room in our state following a burn any different from such a child in Honduras? Why are sick and injured uninsured people frequently dismissed and cast off as "dirt balls" when the good feelings generated by helping these children (in Honduras) reminded us of the fundamental reasons we all went into medicine? Physicians do not have to travel hundreds of thousands of miles around the world in order to provide care that would be greatly accepted right in our own community.

There is, of course, no easy answer to providing appropriate medical care to everyone while not bankrupting those who funded. Economic motivations to overtreat are offset by forces that frequently may lead to undertreatment (also economic). Unfortunately, while organized medicine is worried about urine drug testing for physicians, the lawyers and corporations (including HMOs) are rapidly correcting the misguided motivation of physicians. I hope, but frequently doubt, that the independence of the physician to care for his patients will not be lost. It is a shame that while organized medicine is urinating into specimen cups, the problem of providing medical care will likely be solved by non-physicians.

As a physician further loses his independence his motivation will be controlled by others. He will no longer have to worry about what to do with all his money (there will not be as much) and the medically indigent population may have the benefit of better medical care access, although provided by a less cheerful physician.

John Russin, M.D.
Hollywood, FL

Editor's Comment: Providing medical care to the indigent is far more complex than changing the motivations of physicians or asking them to make an extra sacrifice of time and effort. Most physicians are still guided by altruistic motives and continue to provide a substantial amount of uncompensated medical care to the needy. I am also quite sure that they don't turn down patients just because they happen to have no insurance.

I think it is laudable that some physicians can take time away from their practices to provide free medical services to people in a few undeveloped countries. Unfortunately, juxtaposing that concept to the problem of indigent care here does not provide the answer. The circumstances in the two situations are entirely different. (An article on page 283 of this issue,

I Am Afraid, by Dr. Richard Rubinson, provides some insights into one aspect of the indigent care problem).

The FMA under the able leadership of Dr. James Perry has taken the lead in trying to seek solutions to the indigent care problem and has been working with various legislators on this issue. Even while physicians may be urinating into cups, Dr. Russin can rest assured that they are also capable of doing other equally rewarding things.

Remembering Terri Carver

Mrs. Terri Carver died in Jacksonville on February 13. I had the wonderful experience and the distinct pleasure of knowing Terri for more than 20 years. Her husband, Jack, was my medical school roommate while we were students in Chicago. Terri was dating Jack and we spent many happy hours together while Terri was in nursing training there. Terri and Jack married after graduation and moved to New York while I moved to Florida. After they moved to Florida, I saw Terri and Jack about three years ago when they arrived here for Terri's cancer treatment.

Since then my wife and I have spent many hours with Terri. She never lost her great sense of humor; she never lost her strong will and family love; and she never lost her concern for her friends. Her work with the Auxiliary continued as evidenced by her recent article. I had the privilege of knowing members of her family and watched them return her support and love to the end. What we lost when Terri left us is somewhat compensated by what we gained while she was with us. Terri Carver was true to her family, true to her friends, true to her profession and true to her God.

Robert V. Joel, M.D.
Jacksonville

Terri Carver was Chairman of the International Health Committee, FMA-A.

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Suggestions on the malpractice problem

Florida law gives us the option to practice medicine without malpractice insurance if we inform our patients that we are doing so. I propose that we do the following to control the horrendous malpractice situation:

1. Transfer ownership of our assets to a dear one.
2. Form a board that studies medical bad results.
3. Create compulsory assignment of 50% of our current malpractice premium, while active in medicine, to a Florida State Fund, administered by the medical board, to compensate the victims of bad results. The FMA could serve as the basis of this initiative.

The benefits would be the following:

1. The public would know of our desire and commitment to compensate those who may fall victim to our human condition.
2. The parties that are profiteering from the current crisis would be exposed.
3. We would regain the essential trust on which the doctor-patient relationship stands.

Peter H. Obesso, M.D.
Palm Harbor, FL

Machiavellian ending

We were pleased to hear from Jacques R. Caldwell, M.D. (JFMA, February, 1987, Vol. 74, No. 2) about our "misinterpretation" of his article, "Messages From Machiavelli" (JFMA, October, 1986, Vol. 73, No. 10).

We are in agreement that "Doctors have inherited a tradition of ethical standards that reach back into antiquity. The integrity that those standards impose must always be applied in our practices, in our science, in our teaching and in our dealings with our patients and colleagues."

In any event, we are glad that we are on the same "wave lengths" with our friend and colleague.

Richard F. Lockey, M.D.
Samuel C. Bukantz, M.D.
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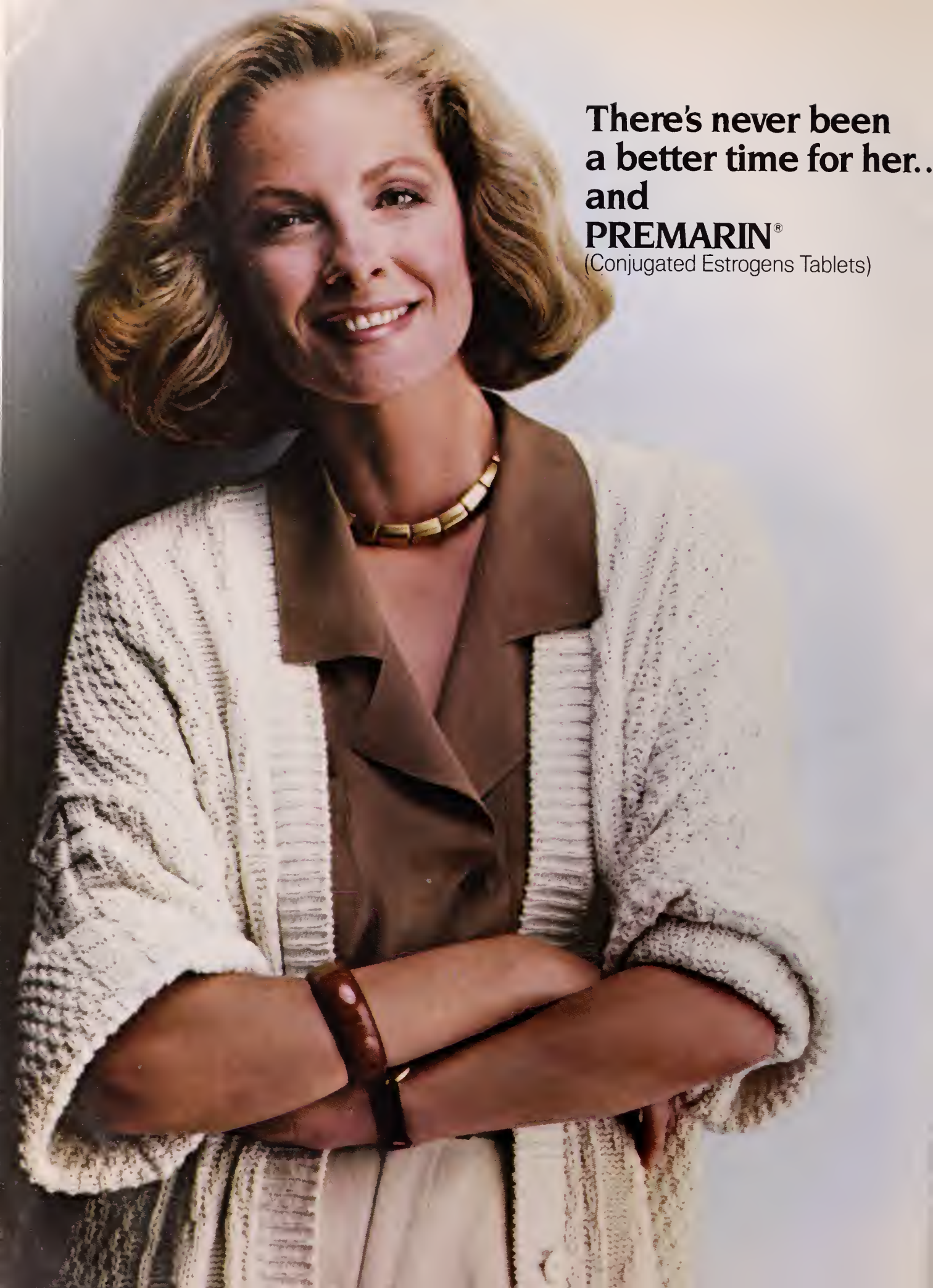
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2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

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INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605 **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985; 67: 496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219

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Ayerst® AYERST LABORATORIES
New York, NY 10017

T6194/886

Motrin® 800 mg TABLETS
ibuprofen



Extra strength
Convenience
Economy

Upjohn
A Century of Caring
1886·1986

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J-6138 January 1986



There's never been a better time for her... and PREMARIN®

(Conjugated Estrogens Tablets)

Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®
(Conjugated Estrogens Tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®
(Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

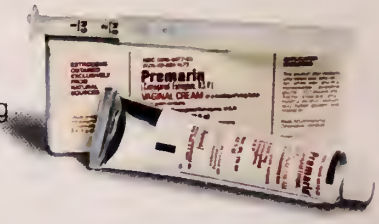
The appearance of these tablets is a trademark of Ayerst Laboratories.

For atrophic vaginitis

PREMARIN®
(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

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WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

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c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985; 67: 496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219

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T6194/886

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH)). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

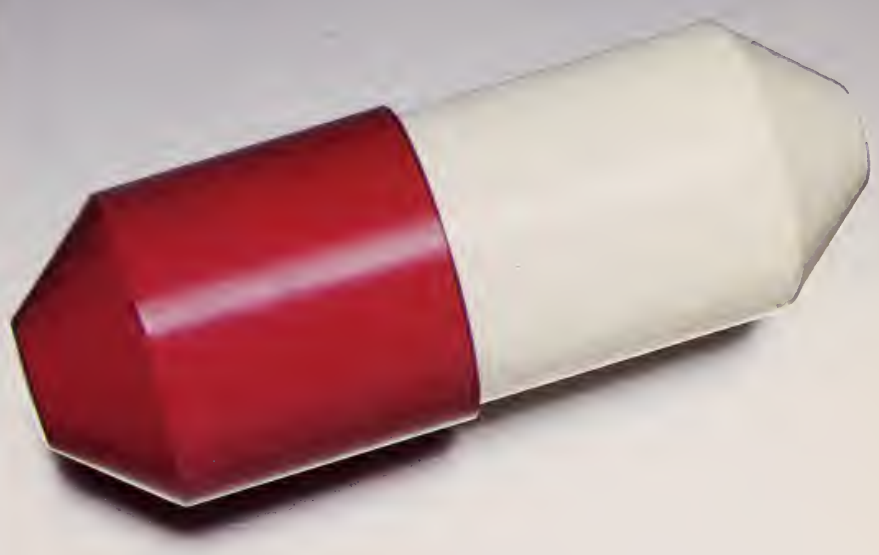
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L42

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 20 Years of Confidence

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.

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SYNCHRONIZED SULFONYLUREA THERAPY

Please see brief summary of Glucotrol® (glipizide) prescribing information on next page.

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Reference:
1. Sachs R, Frank M, Fishman SK. Overview of clinical experience with glipizide. In *Glipizide: A Worldwide Review*. Princeton, NJ, Excerpta Medica, 1984, pp 163-172

GLUCOTROL® (glipizide) Tablets
Brief Summary of Prescribing Information

INDICATIONS AND USAGE: GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate trial of dietary therapy has proved unsatisfactory.

CONTRAINDICATIONS: GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin.

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY: The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes*, 19, supp. 2:747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2-1/2 times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy.

Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

PRECAUTIONS: Renal and Hepatic Disease: The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function. Hypoglycemia may be prolonged in such patients should it occur.

Hypoglycemia: All sulfonylureas are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemia. Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions. Elderly, debilitated or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

Loss of Control of Blood Glucose: A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery. It may then be necessary to discontinue GLUCOTROL and administer insulin.

Laboratory Tests: Blood and urine glucose should be monitored periodically. Measurement of glycosylated hemoglobin may be useful.

Information for Patients: Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and/or blood glucose. The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members. Primary and secondary failure should also be explained.

Drug Interactions: The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including nonsteroidal anti-inflammatory agents and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta adrenergic blocking agents. *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicumarol. However, caution must be exercised in extrapolating these findings to a clinical situation. Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid. A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported. Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known.

Carcinogenesis, Mutagenesis, Impairment of Fertility: A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity. Bacterial and *in vivo* mutagenicity tests were uniformly negative. Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility.

Pregnancy: Pregnancy Category C. GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide. The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL. In studies in rats and rabbits no teratogenic effects were found. There are no adequate and well controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible.

Nonteratogenic Effects: Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery. This has been reported more frequently with the use of agents with prolonged half-lives. GLUCOTROL should be discontinued at least one month before the expected delivery date.

Nursing Mothers: Since some sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: In controlled studies, the frequency of serious adverse reactions reported was very low. Of 702 patients, 11.8% reported adverse reactions and in only 1.5% was GLUCOTROL discontinued.

Hypoglycemia: See PRECAUTIONS and OVERDOSAGE sections.

Gastrointestinal: Gastrointestinal disturbances, the most common, were reported with the following approximate incidence: nausea and diarrhea, one in 70; constipation and gastralgia, one in 100. They appear to be dose-related and may disappear on division or reduction of dosage. Cholestatic jaundice may occur rarely with sulfonylureas. GLUCOTROL should be discontinued if this occurs.

Dermatologic: Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria, pruritus, and eczema have been reported in about one in 70 patients. These may be transient and may disappear despite continued use of GLUCOTROL; if skin reactions persist, the drug should be discontinued. Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, and pancytopenia have been reported with sulfonylureas.

Metabolic: Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas. Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions.

Endocrine Reactions: Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) secretion have been reported with this and other sulfonylureas.

Miscellaneous: Dizziness, drowsiness, and headache have been reported in about one in fifty patients treated with GLUCOTROL. They are usually transient and seldom require discontinuance of therapy.

OVERDOSAGE: Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia. If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL. Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery. Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease. Because of the extensive protein binding of GLUCOTROL (glipizide), dialysis is unlikely to be of benefit.

DOSAGE AND ADMINISTRATION: There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL, in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia.

Initial Dose: The recommended starting dose is 5 mg before breakfast. Geriatric patients or those with liver disease may be started on 2.5 mg. Dosage adjustments should ordinarily be in increments of 2.5-5 mg, as determined by blood glucose response. At least several days should elapse between titration steps.

Maximum Dose: The maximum recommended total daily dose is 40 mg.

Maintenance: Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing. Total daily doses above 15 mg should ordinarily be divided.

HOW SUPPLIED: GLUCOTROL is available as white, dye-free, scored diamond-shaped tablets imprinted as follows: 5 mg tablet—Pfizer 411 (NDC 5 mg 0049-4110-66) Bottles of 100, 10 mg tablet—Pfizer 412 (NDC 10 mg 0049-4120-66) Bottles of 100.

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Cardiac transplantation in private practice

R. Vijayanagar, M.D., Paul F. Eckstein, M.D., Diane L. Jeffery, M.D., and Katherine R. Rogers, R.N.

ABSTRACT: Tampa General Hospital, in affiliation with the University of South Florida College of Medicine, was the first institution to provide services for cardiac transplantation in the State of Florida. The transplant team consists of both private and University affiliated physicians. There are currently two surgical teams. From Jne 1985 through November 1986, ten consecutive cardiac transplantations have been performed. There has been one operative death, one late death due to severe cytomegalic virus septicemia and moderate rejection, 15 rejection episodes, and 12 infectious complications. Immunosuppressive therapy included cyclosporine-A, azathioprine, and steroids. Pulse Solum Medrol therapy, rabbit or horse antilymphocytic serum, or monoclonal antibody (OKT3) were used for acute rejection. Eight patients are alive and well from 3-17 patient months. Six patients are gainfully employed, one is happily retired, and one is unemployed. Thus, cardiac transplantations can be effectively performed in private practice when the transplant team consists of dedicated physicians and related personnel fully committed and appropriate resources.

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Orthotopic cardiac transplantation procedures have become relatively common since the release of cyclosporine-A by the Food and Drug Administration.[1-6] As of December 1986 more than 90 hospitals in the United States have been involved in cardiac transplantation procedures, and 2,062 heart transplantations have been performed in the United States through March 1986.[7] Presently, the only prerequisite to program development in Florida is the presence of an active open heart surgical service and an existing renal transplant program. This article examines the success of a cardiac transplantation program in a county hospital with university affiliation. The authors are in a private cardiac surgery practice within this institution.

Planning for cardiac transplantation program • The Tampa General Hospital has been providing major cardiology and surgical services for the west coast of Florida for approximately two decades. In addition, renal transplantation services have been in place for a few years. Unfortunately, suitable patients who could benefit from heart transplants were referred to out of state institutions. Considering these factors, a multidisciplinary committee was appointed by the medical staff and a program feasibility study was conducted. Committee members included cardiologists, surgeons, immunologists, infectious disease service, pulmonologists, pathologists, psychiatrists, nursing service, organ procurement foundation and, most important of all, a competent transplant coordinator.

Members responsible for the transplant team attended various postgraduate courses, visited various transplant centers, conducted numerous transplant drills, and prepared a protocol. Transplant drills included cadaver practice of retrieval and transplanting techniques. On site peer review was obtained by visiting specialists in this field and approval of the protocol was obtained. Following approval of the program and completion of the team's training, appropriate recipients were screened.

Material and Methods • On June 6, 1985, the team performed Florida's second orthotopic heart transplant procedure. Although thus far 17 heart transplantation procedures have been performed, we report the results of ten consecutive orthotopic heart transplants from June 1985 through November 1986. The recipients included nine males and one female whose ages ranged from 25 to 62 with the mean age of 49.7 years. Two patients were dependent on maximum intravenous inotropic support and five were in-hospital patients. The remainder were between Class III and IV. Four patients had cardiomyopathy of unknown etiology, three had ischemic cardiomyopathy, two had valvular cardiomyopathy and one suffered from Adriamycin-induced cardiomyopathy. Recipients were carefully screened for pulmonary hypertension. If pulmonary vascular resistance was greater than three wood units, testing was carried out with intravenous nitroprusside. Details about the recipient data are listed in Table 1. Local donors were found for five recipients, regional for four, and distant donor for one.

Appropriate body weight, blood typing, and lymphocytic cross matching were used prior to selecting the proper donor. Data on the donors are listed in Table 2. Ischemic times for the donor heart varied from 60 to 225 minutes (115.5 minutes mean ischemic time). If the donor was older than 35 years for a male and 40 years for a female, coronary angiogram was performed prior to accepting the donor heart.

Results and follow-up • One patient died in the operating room for a mortality of 10%. This patient had three previous cardiac procedures for aortic valve replacement and there were many technical difficulties. Death was related to failure of the transplanted donor heart. There has been one late death as a result of moderate rejection and septicemia secondary to cytomegalic virus. The mean hospital stay was 23.62 days. Eight survivors are alive and well from three months to 17 months with a 9.5 month mean follow-up. The number of rejection episodes for each survivor, infectious complications, and other details are shown in Tables 3A and B. As of December 1986, at least six patients are gainfully employed, one is happily retired, and one patient is unemployed.

Once the histocompatibility testing was performed and a proper donor identified, the recipient was immediately hospitalized. The preoperative loading dose of immunosuppression consisted of oral cyclosporine-A 12-15 mg/kg and azathioprine 150 mg. The patients received intravenous methylprednisolone during surgery and immediately postoperatively. Intravenous cyclosporine-A, with the exception of the first two patients, has been avoided because of renal complications. Azathioprine was reinstituted postoperatively. Cyclosporine levels were monitored serially, and the dosage adjusted accordingly.

The first endomyocardial biopsy (EMB) was performed six to seven days postoperatively and at weekly intervals for approximately six weeks. Acute rejection episodes were treated with pulsed intravenous steroids, rabbit or horse antilymphocyte globulin, or intravenous OKT 3 monoclonal antibody. Infectious problems were identified promptly and treated accordingly (Table 3B).

Late follow-up • At this time, the eight survivors are in Class I. All have required psychosocial adjustment after discharge. There have been three late rejection episodes and four late infectious complications. Complications of rejection and infection are considered to be late after three months. The details of these are listed in Table 3B. Acute rejection episodes have been a problem in the immediate postoperative period and extending up to about three months. Late rejection, thus far, has not been a major problem. Late infectious problems have been 1 bacterial, 1 viral, 1 fungal, and 1 protozoan. There have not been any major difficulties in clearing these infectious complications. Overall, the experience with cardiac

Table 1. — Recipient Clinical Data.

		Age	Sex	Clinical Status (NYHA)	Body Weight (#)	Blood Group	Cardiomyopathy Etiology
1.	TT	42	M	IV	155	A+	Idiopathic
2.	FS	43	M	IV	128	O+	Adriamycin-Induced
3.	RS	25	M	IV	124	O−	Idiopathic
4.	GH	35	M	IV	140	A+	Ischemic
5.	TF	61	M	IV	108	A+	Ischemic
6.	JZ	56	F	III-IV	145	A+	Idiopathic
7.	NT	56	M	IV	165	O+	Valvular
8.	LF	57	M	IV	140	O+	Valvular
9.	JK	59	M	III-IV	190	O+	Ischemic
10.	MB	62	M	III-IV	140	A+	Idiopathic

Table 2. — Donor Data.

	Age	Sex	Local	Regional	Distant	Blood Group	Body Weight (#)	Ischemic Time (Minutes)
1.	19	M	X			O+	160	95
2.	20	M			X	O+	140	225
3.	25	F		X		O+	125	90
4.	32	M	X			O+	160	95
5.	30	M	X			O+	130	90
6.	22	F	X			A+	120	80
7.	41	F	X			O+	110	60
8.	48	F		X		O+	140	210
9.	22	M		X		O−	170	60
10.	18	F		X		A+	140	150

transplantation at Tampa General Hospital has been very gratifying.[1-16]

Discussion • The technique of cardiac transplantation was originally described by Lower and Shumway in the animal research laboratory (1960).[8-10] Years of animal research culminated in the first primate to human heart transplantation performed by Hardy (1964),[11] followed by human to human heart transplantation popularized by Barnard (1967).[12] Early enthusiasm gradually dissipated among many centers due to high mortality secondary to severe rejection episodes and infectious complications.[9-14] Upon the release of cyclosporine-A for general use and the advent of EMB procedures to rapidly recognize trends in rejection, cardiac transplantation began to gain widespread popularity in the early 1980s.[1-6,13-16] University centers and private hospitals alike have now begun to offer cardiac transplantation services.

In Florida a cardiac transplant procedure was reportedly performed at the Miami Heart Institute in the late 1960s with technical success achieved. It was not until June 1985 that the second was performed within the state at the Tampa General Hospital. This patient, alive and doing very well 18 months following surgery, is the longest surviving patient of the procedure performed in the state. Four hospitals in Florida offer cardiac transplantation services. Two are located in Tampa and one each in Gainesville and Tallahassee. Others have been reported as planning to provide this service.

Secondary to improved survival statistics, an increasing number of institutions would like to become involved in cardiac transplantation. Currently no state guidelines exist; therefore, a certificate of need is not required. In the northeast, government permission is required to provide such services. Columbia University is the only institution authorized to perform cardiac transplantation in New York City. At present, a Governor's commission is apparently working on this project in Florida.

Table 3-A — Results and Follow-Up.

Number of Heart Transplants	10
Operative Death	1 (10%)
Late Death	1 (10%)
Mean Hospital Stay	23.62 days
Alive and Well	8
Follow-Up	95 total patient months (3 — 17 months)
Employed	6
Retired	1
Unemployed	1

Tampa General Hospital was the first hospital in Florida to provide this service and has been very successful to date. Thus far, 16 orthotopic and 1 heterotopic cardiac transplantation procedures have been performed. The average hospital stay has been 23.62 days; one patient being discharged home on the eighth postoperative day. The hospital is a fully affiliated teaching hospital with the University of South Florida College of Medicine.

The University and Tampa General have developed and maintained an extremely successful renal transplant program. Although experience and useful information may be derived from an existing renal transplantation service, it is our opinion that it should not be considered an absolute requirement precluding cardiac transplant services.

The cardiac transplant committee consists of multidisciplinary physicians of both private and university affiliated practice, as well as other health care professionals. A private and a University surgical team perform cardiac transplantation on a routine basis. We have instituted a cardiac transplant outpatient clinic and disposition conference held once a week. The multidisciplinary committee members

Table 3-B. — Rejection and Infection Episodes and Follow-Up.

	Status	Number Months Postop	Early Rejection (3 months)	Early Infection (3 months)	Late Rejection	Late Infection
1.	Alive	17	2	1 Bacterial	0	1 Bacterial
2.	Alive	17	2	1 Bacterial	0	0
3.	Alive	15	2	0	1	1 Fungal
4.	Alive	8	1	0	0	0
5.	Alive	8	2	1 Bacterial 1 Fungal	1	1 Viral
6.	Alive	6	0	1 Fungal	0	1 Protozoan
7.	Alive	3	1	0	0	0
8.	Dead	0	-	-	-	-
9.	Alive	3	1	1 Fungal	1	0
10.	Dead	1	1	1 Bacterial 1 Viral	-	-

participate in the disposition conference to present new transplant candidates for surgical consideration, to discuss EMB and laboratory results, and to formulate future management strategies regarding transplant recipients.

In order to create and maintain a successful cardiac transplant program, several criteria are necessary. First, the program must be affiliated with a competent organ procurement facility. We believe that this is one of the most important requirements to ensure program success. In addition, the program needs an organized, competent transplant coordinator, and dedicated physicians willing to make a total commitment. It is also extremely important to have qualified pathologists to evaluate tissue slides for rejection and immunologists to guide patient treatment.

In summary, we believe that cardiac transplantation is feasible in a community hospital where a viable cardiac surgical program exists. An existing renal transplant program is helpful but not absolutely mandatory. Physicians knowledgeable with techniques of cardiac surgery, immunology, infectious disease, pathology, transplant psychology, and an administration with full commitment is required. University affiliation serves as an excellent asset.

ADDENDUM: Since the submission of this manuscript the authors have performed one additional cardiac transplant. Twenty-one cardiac transplants have been performed so far. One additional late death has occurred 18 months after transplant. Cause of death by autopsy was acute cardiac rejection.

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Thrombotic complications of the Hickman catheter

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ABSTRACT: The Hickman catheter has been useful for central venous catheterization. It is implanted percutaneously or by surgical cutdown. Infection at the exit site and generalized sepsis occur as with other catheters but seemingly at a reduced rate. Its silicone rubber composition does not favor thrombotic complications nor vascular perforation although these complications continue to be reported. The large diameter of the catheter relative to the Broviac and Port-A-Cath may be disadvantageous. Certainly, long-term implantation of any catheter invites complications. As yet a totally satisfactory system for central venous catheterization has not been described.

Since the first report of the technique in 1952, central venous catheterization has become an established procedure in current medical therapy. There has been a continuing interest in venous access techniques and in catheters of varying design, hoping to reduce complications of the procedure, some of which are lethal. The subclavian and internal jugular veins are most commonly used for access to the superior vena cava. They are approached percutaneously by needle puncture or by surgical cutdown. A comprehensive review of possible venous approaches is detailed by Parsa et al.[1]

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Complications related to technique and catheter placement include perforation of the heart or great vessels, cardiac tamponade, hemothorax, pneumothorax and hydrothorax, mediastinitis, clotting around the catheter and catheter displacement. Immediate complications at the time of needle puncture and catheterization should be recognized and treated according to need. Cardiac arrhythmias, pneumothorax, arterial puncture, puncture of lymphatic ducts and air embolism may not be obvious immediately but their identity cannot be neglected. Infection at the exit site of the catheter or generalized sepsis may be the most frequently recognized complication.[1-6] A higher rate of serious complications is expected when teflon catheters are used. These are more rigid and less pliable than catheters made of polyethylene, polyurethane, and silicone rubber. Many catheters are inserted over a guide wire which has been implicated as the cause of perforation.[5] The J-shaped flexible guide wire is preferred. A soft silicone rubber catheter was introduced by Broviac in 1973 and modified by Hickman in 1975. The Hickman catheter has been widely used and being of larger diameter is more functional than the Broviac.[7-8]

Since central venous catheterization for intravenous therapy and monitoring is an effective treatment modality, and since the Hickman catheter seems suited for long-term use, one should be aware of serious complications that may occur and therapy should be adjusted accordingly. Three cases are reported with serious complications which occurred during lengthy chemotherapy administered through Hickman catheters.

Report of cases • Case 1. — In a 41-year-old white male who had undergone a radical left colectomy for carcinoma of the rectosigmoid, a Hickman catheter was introduced on July 20, 1982 through the right subclavian vein into the superior vena cava. It was removed on December 7, 1982 because of infection at the exit site. On that date a Hickman catheter was introduced through the left subclavian into the superior vena cava and remained until September 18, 1984. The catheter was in place for 650 days and chemotherapy with 5FU by low dose constant infusion was completed during this time. In June 1984 the patient experienced pain in the anterior chest, neck and shoulders. Intrasynovial steroid injections in the chest did not bring relief. The complaints worsened and in August 1984 he was admitted to the hospital with increasing pain in the shoulder girdle and chest requiring narcotics for relief. A superior vena caval syndrome was evident with distention of neck veins, swelling of face and eyelids, and mediastinal widening on x-ray. Metastatic carcinoma was suspected. Anterior thoracotomy was performed on August 24, 1984 and multiple biopsies of mediastinal nodes and tissue were performed and the pathology report was returned as "reactive hyperplasia of lymph nodes, fibroadipose tissue with necrosis." All cultures of the mediastinum and blood cultures were negative. The Hickman catheter remained in place until removal on September 18, 1984 and at this time it was believed that he had superior vena caval syndrome due to thrombosis and extravasation of 5FU with inflammatory changes in the mediastinal tissue.



Fig. 1. — Mediastinal widening due to mediastinitis.



Fig. 2. — Widening superior mediastinum, right side.

Following removal of the catheter, his symptoms improved and within several weeks he was virtually asymptomatic. His improvement has been steady although he has some minor residua of the superior venal caval syndrome (Fig. 1).

Case 2. — A white male, age 56, had an anterior resection of the rectum for Duke's C carcinoma of the rectum on November 23, 1983. A Hickman catheter was introduced into the vena cava via the right subclavian on December 5, 1983 and low dose adjuvant 5FU chemotherapy by continuous infusion was instituted. A total of 4000 rads were delivered to the pelvic area by linear accelerator. The low dose 5FU infusion was continued until April 17, 1985 when the Hickman catheter was removed. It was in place 493 days. This patient was admitted to the hospital on April 17, 1985 with a complaint of right-sided chest pain for several days. Chest x-ray revealed enlargement of the mediastinum interpreted as hemorrhage into the wall of the superior vena cava and mediastinum at the site of the catheter tip. The catheter was removed and thereafter all symptoms disappeared (Fig. 2).

Case 3. — A 55-year-old white female underwent a modified radical mastectomy on the left side for carcinoma of the breast with node metastases on April 14, 1984. Chemotherapy was instituted on March 30, 1984 when a Hickman catheter was passed through the left subclavian vein into the vena cava. On January 9, 1985 she was seen with a complaint of burning pain anteriorly in the chest and pain in the left infraclavicular area. A venogram was performed which demonstrated thrombus, perforation and false

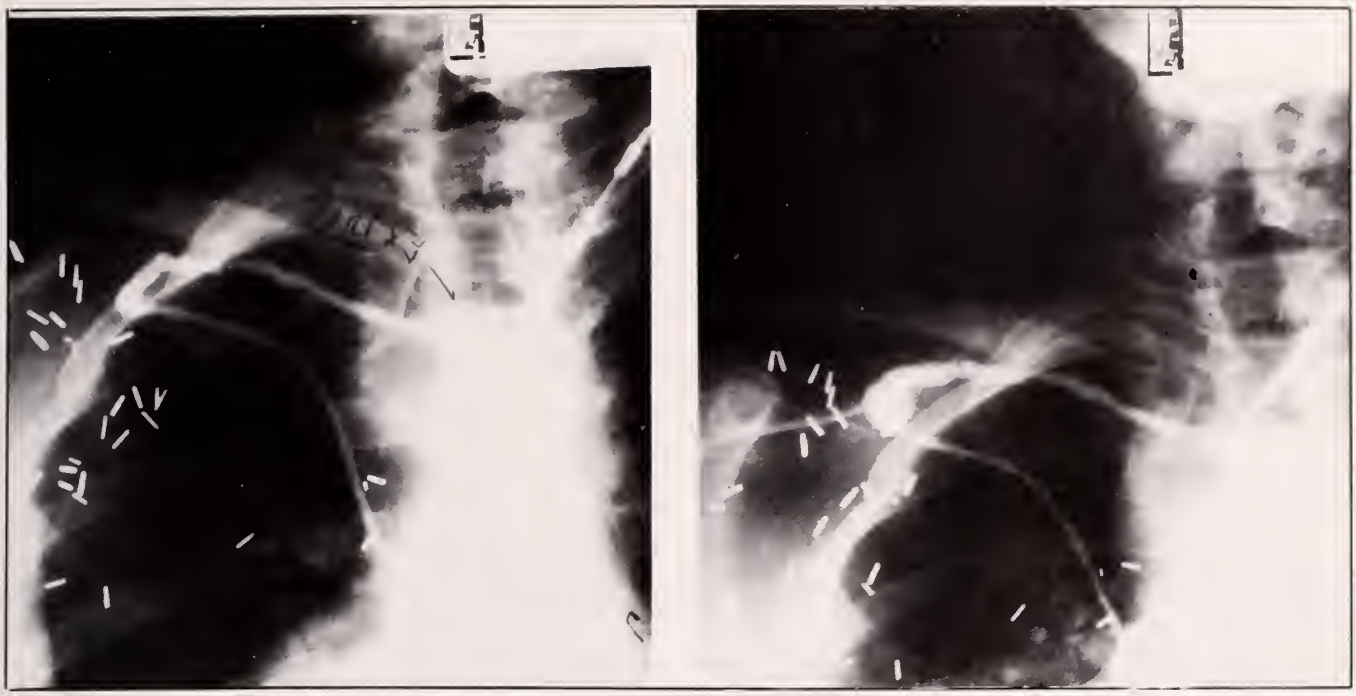


Fig. 3. — Venogram, false aneurysm subclavian vein and extravasation of contrast medium.

aneurysm formation in the subclavian vein with extravasation of the contrast media. The catheter was removed on January 9, 1985 and thereafter all symptoms disappeared and she experienced no further problems. The catheter had been in place 286 days. (Fig. 3)

Comment ● These three cases illustrate that serious complications can occur with extended use of the Hickman catheter. Thrombotic complications of venous catheters are related to the formation of a fibrinous sheath around the catheter.[1, 2, 3] This forms almost immediately after placement. Progression of the process is indeterminate until the thrombotic occlusion of a large vein becomes evident. The fixation of the catheter against the vessel wall by the thrombus promotes perforation of the vessel wall. The incidence of thrombotic complications is less with the silicone rubber catheter than those of other composition. However, thrombosis around catheters relates to diameter, length, and rigidity of the catheter. By inference, the larger diameter of the Hickman catheter is disadvantageous. The incidence of trombotic complications can be reduced by changing the catheter at frequent intervals. This would be equated with the expense of multiple procedures and the increasing risk of immediate complications, and also patient acceptance. In a review of more than 9,000 cases, erosion through the vessel wall did not occur using the 8 inch 16F polyethylene, semirigid, Intracath, manufactured by Deseret Medical. Catheter change is advocated every two weeks, with a range of 1-60 days.[1]

Green has reported favorably on the totally implantable Port-A-Cath.[9] This is a subcutaneous reservoir with a small diameter silicone catheter. Comparison of a patient group in which this device was used a patient group using Hickman and Broviac catheters demonstrated significantly less infections and no thrombotic complications in the Port-A-Cath group.

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Timing hospital discharge following vaginal hysterectomy

Jack Lucas, M.D., William S. Roberts, M.D., and James M. Ingram, M.D.

ABSTRACT: A study group of 180 patients undergoing vaginal hysterectomy at Tampa General Hospital January 1980 to November 1984 was reviewed retrospectively. The incidence of intraoperative and postoperative morbidity was determined and related to the length of hospital stay. Febrile morbidity developed in 9.4% of patients; it was evident by the third postoperative day in all but two. These two patients were readmitted two weeks or longer after surgery for pelvic infection. Ten percent of patients required transfusion and 6.6% developed urinary retention. The need for transfusion was determined by the third postoperative day in all patients. All patients with urinary retention had anterior colporrhaphy in addition to vaginal hysterectomy. Unanticipated additional surgery was necessary in six patients and one patient each required repair of a proctotomy and cystotomy. One patient developed a femoral neuropathy that resolved spontaneously and one patient had a hypotensive episode in the recovery room that resolved with fluid therapy. Discharge after the third postoperative day seems safe in patients who undergo an uncomplicated vaginal hysterectomy.

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Prior to institution of Diagnostic Related Groups (DRGs), the day of discharge from the hospital was of moderate interest or concern. Since this policy has been instituted at Tampa General Hospital, and most other hospitals, interest has greatly increased in the postoperative management and hospital discharge of the surgical patient. Therefore, the objectives of this study are to identify factors associated with prolonged hospital stay in patients undergoing vaginal hysterectomy, to determine the optimum day of discharge following operation and to examine the issue of whether premature discharge has led to unpredictable and costly readmission to the hospital.

Materials and methods • All charts available for review of patients undergoing vaginal hysterectomy at Tampa General Hospital from January 1980 to November 1984 were studied retrospectively. The study group included 180 patients. Particular emphasis was placed on examining the intraoperative and postoperative course in relationship to the day of discharge from the hospital.

In an effort to establish the safest and earliest day of discharge, patients were divided into two groups based on occurrence or nonoccurrence of intraoperative or postoperative complications. Complications included febrile morbidity, excessive blood loss, urinary retention, neurologic deficit related to the surgery, unanticipated additional surgery to correct intraoperative and postoperative complications and acute life-threatening events. Indications for rehospitalization were examined. Febrile morbidity was defined as an oral temperature of 100.4°F or greater on two postoperative days excluding the first 24 hours after surgery. Excessive blood loss was defined as that requiring blood replacement intraoperatively or postoperatively. Acute life-threatening

Table 1. — Patient and Operative Variables.

	No Complication	Complication
Total number of patients (n = 180)	130	50
Age	mean 37.4 yr. range 20-80 yr.	39.8 yr. 21-84 yr.
Menopausal status: premenopausal postmenopausal	106 (81.5%) 24 (18.5%)	40 (80%) 10 (20%)
Additional surgery	no 73 (56%) yes 57 (44%)	16 (32%) 34 (68%)
Experience of primary surgeon	attending 33 (25%) resident 97 (75%)	11 (22%) 39 (78%)
Mean operative time: hysterectomy alone additional surgery	131 min. 168 min.	144 min. 186 min.

events included any intraoperative or postoperative hypotension.

In addition to specific complications, other variables affecting hospital stay were considered. These included age, menopausal status, additional surgery, experience of the primary surgeon and the operative time.

Results ● Patient and operative variables in relationship to occurrence of complications are seen in Table 1. Patients developing complications were 2.4 years older on the average than those who did not develop complications. Approximately 80% of patients were premenopausal in both groups. Additional surgery resulted in a significantly higher complication rate. The resident to attending gynecologist ratio as primary surgeon was constant between complicated and uncomplicated cases. Mean operative time was significantly longer in patients developing complications. All complications observed in the series are summarized in Table 2.

Table 2. — Complications.

Febrile morbidity	**14**
Operative site infection	10
UTI	1
Source unidentified	3
Excessive blood loss	**18**
Intraoperative transfusion	11
Postoperative transfusion	7
Urinary retention	**12**
Unanticipated procedure	**7**
Intraoperative	6
Postoperative	1
Life-threatening event	**1**
Acute hypotension	1
Other	0
Neurologic deficit	**1**
Readmission	**4**
Infection	3
Bleeding	1

Febrile morbidity occurred in 9.4% of patients. The predominant causative factor was operative site infection. Prophylactic antibiotics were administered in 93.8% of all cases. In the preponderance of cases, the febrile illness began on the second postoperative day. No patient developed a fever beyond the third postoperative day. In patients developing a fever, the average day of discharge was 7.1 days.

Excessive blood loss occurred in 18 patients for a rate of 10%. Postoperative transfusions were given on days one through four. Blood was more commonly given on the second postoperative day. Patients receiving a blood transfusion were discharged a mean of 6.8 days after surgery.

Urinary retention affected 12 patients (6.6%) and all of them had undergone hysterectomy and vaginal repair. Bladder drainage was accomplished by suprapubic catheter in 83.3% and by transurethral Foley catheter in the remaining 16.7%. Among patients not developing urinary retention, 62.5% were managed with suprapubic drainage and 37.5% with transuretheral Foley catheter. Urinary retention occurred primarily on postoperative days three through six. The average hospitalization for these patients was 9.9 days.

Unanticipated procedures occurred in seven patients; six intraoperatively and one postoperatively. Intraoperatively, four laparotomies were performed to control bleeding, and repair of incidental cystotomy and proctotomy occurred once each. One postoperative laparotomy was performed to control bleeding. Average discharge was 7.5 days if an unanticipated operative procedure was performed.

Only one acute life-threatening event occurred. A hypotensive episode occurred 30 minutes postoperatively following an otherwise uncomplicated vaginal hysterectomy. This responded to intravenous fluid and Trendelenburg position. No specific etiology for this event was ever found. This patient was discharged on the sixth postoperative day.

A unilateral femoral neuropathy developed in one

patient following an otherwise uncomplicated vaginal hysterectomy. This condition was treated conservatively with a knee brace and resolved spontaneously. The patient was discharged in six days.

Four patients required readmission to the hospital for indications directly related to the previous surgery. Three patients were admitted for infection, two for cuff cellulitis, and one for an infected anterior vaginal wall hematoma. Another patient was admitted because of persistent vaginal bleeding. Both patients who had cuff cellulitis received prophylactic antibiotics perioperatively, remained afebrile throughout the immediate postoperative period and were readmitted two weeks postoperatively or later. They received additional antibiotics upon readmission with resolution of the infection. The patient readmitted because of an infected hematoma also had received prophylactic antiobiotics perioperatively and had remained afebrile immediately postoperatively. She was initially discharged on the seventh postoperative day and was readmitted the following day for evacuation of the hematoma and intravenous antibiotics. An additional patient was readmitted because of persistent vaginal bleeding ten days postoperatively. She had undergone vaginal hysterectomy and anterior colporrhaphy without complication. She had an uneventful postoperative course with an adequate hemoglobin level and was discharged four days after surgery.

The average day of discharge for all uncomplicated cases was 5.3 days. Hospital stay was extended by 2.3 days in complicated cases overall.

Comment ● The age and menopausal status of the patients and the experience of the surgeon surprisingly were not predisposing factors to postoperative morbidity in this study. Additional surgery was associated with a higher rate of complications which is not surprising. As could be expected, operative time was extended in the complicated cases. Extended operative time has been shown by others to contribute to postoperative morbidity following vaginal hysterectomy.[1]

Postoperative pelvic infection is the most common complication associated with vaginal hysterectomy and accounts for most instances of febrile morbidity. The reported incidence of operative site infection after vaginal hysterectomy averages 30% to 40% and has been reported as high as 70%.[2] In this study the infection rate was 9.4% which is considerably lower than might be expected. This low rate is very likely attributable to the liberal use of prophylactic antibiotics. The efficacy of antibiotic prophylaxis in reducing the incidence of postoperative pelvic infection following vaginal hysterectomy has been well established for both pre- and postmenopausal women, and for patients undergoing adnexectomy and concurrent vaginal repair procedures.[2] By dramatically decreasing the occurrence of pelvic infection, prophylactic antibiotics significantly shorten the patient's hospital course following vaginal hysterectomy thus reducing hospital expense. In this series, febrile morbidity extended hospital stay by nearly two additional days on the average. Almost all febrile cases were established by the third postoperative day.[3] The exceptions were those patients readmitted for infection at a time relatively remote from the surgery. Ten percent of patients in this series required either intraoperative or postoperative blood replacement. Porges reports a 6.5% blood transfusion rate in his series.[3] In this series, patients requiring transfusion were equally divided between those undergoing vaginal hysterectomy alone and those with the addition of vaginal repair. The need for postoperative blood replacement occurred during the first four postoperative days and most often on the second day.[2] Hospital stay for all patients receiving a transfusion was extended by about one and one half days on the average.

Inadequate bladder function was the most common indication for extended hospital stay for patients undergoing vaginal hysterectomy and anterior colporrhapy. Urinary retention affected 6.6% of the study population and extended hospital stay by more than four days. Suprapubic bladder drainage was used liberally in this series. The advantages following anterior vaginal repair have long been established. These include increased patient comfort and convenience, conservation of nursing time, and ease of early ambulation. More importantly, there is decreased postoperative morbidity due to decreased urinary tract infection with its use.[4]

Unintended procedures were performed in 3.8% of cases. The bladder and rectum were injured once each and there were no ureteral injuries noted. Four patients (2.2%) required exploratory laparotomy at the time of surgery to control bleeding. Pratt has found the incidence of laparotomy to control bleeding to be 0.25%.[3] In another large series, 1% required intraoperative laparotomy.[5] No patient required laparotomy due to inability to complete the operative procedure vaginally. For patients undergoing an unintended procedure, hospital stay was extended by two days.

There were no intraoperative or postoperative deaths. Thromboembolic disease, which occurs in 0.6 to 1.6% of postoperative patients, did not occur.[6] Likewise, no anesthetic complications were noted.

The patients readmitted to the hospital had uncomplicated intraoperative and postoperative courses. Their readmissions were not predictable. Also, the indication for their readmission was not related to the day they were originally discharged.

Several authors have addressed the issue of hospital discharge following vaginal hysterectomy. Dicker, in a series of 1,851 reproductive-age women, reported a postoperative stay of five days following vaginal hysterectomy and six days following vaginal hysterectomy and colporrhaphy.[5] Ellenbogen reported an average hospital stay of 8.5 days in a series of

postmenopausal women in whom most of the postoperative complications were mild.[7] Copenhaver reported that simple, uncomplicated vaginal hysterectomy does not require a long period of hospitalization and that discharge after a total of three days is adequate. Further, if patients are ambulatory and voiding on the first postoperative day, then discharge on the second postoperative day might be reasonable.[8] For the most part, complications following vaginal hysterectomy as defined in this series occurred between postoperative days one and three. In cases of uncomplicated vaginal hysterectomy alone, it appears that hospitalization through the third noncomplicated postoperative day is adequate. It appears that after this number of days the most common reason for extended postoperative stay, namely, infection and the need for blood transfusion, will no longer be a problem. Patients undergoing vaginal hysterectomy and vaginal repair are subject to urinary retention primarily on postoperative days four through six. After the sixth noncomplicated postoperative day in these cases, most episodes of urinary retention will be manifested; therefore, hospital discharge is considered safe.

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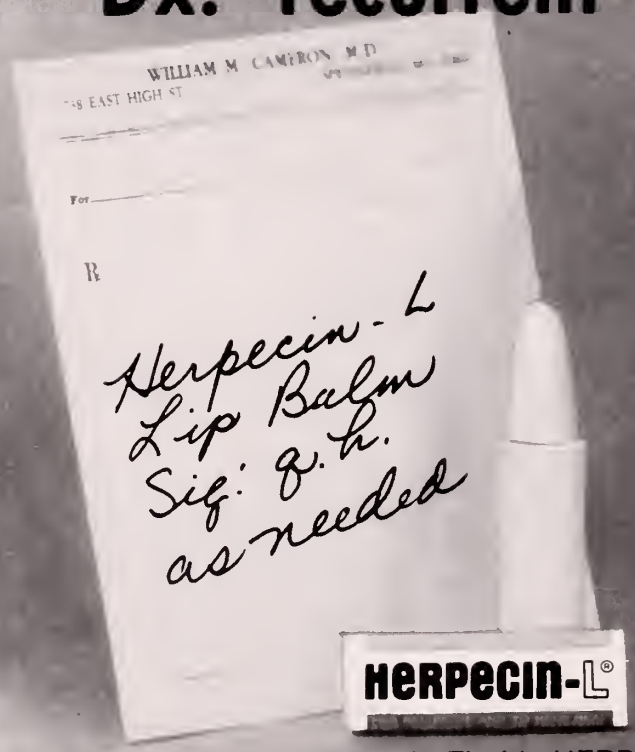
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GRAM-NEGATIVE AEROBES: *Citrobacter freundii, Citrobacter diversus, Providencia* species (including *Providencia rettgeri*), *Salmonella* species (including *S. typhi*), *Shigella* species and *Acinetobacter calcoaceticus*.

ANAEROBES: *Bacteroides* species, *Clostridium* species (Note: most strains of *C. difficile* are resistant).

SUSCEPTIBILITY TESTING: Standard susceptibility disk method. Quantitative methods that require measurement of zone diameters give the most precise estimate of antibiotic susceptibility. One such procedure (Bauer AW, Kirby WMM, Sherris JC, Turck M: Antibiotic Susceptibility Testing by a Standardized Single Disk Method, *Am J Clin Pathol* 45: 493-496, 1966; Standardized Disk Susceptibility Test, *Federal Register* 39: 19182-19184, 1974; National Committee for Clinical Laboratory Standards, Approved Standard: ASM-2, Performance Standards for Antimicrobial Disk Susceptibility Tests, July 1975.) has been recommended for use with disks to test susceptibility to ceftriaxone.

Laboratory results of the standardized single-disk susceptibility test using a 30-mcg ceftriaxone disk should be interpreted according to the following three criteria:

1. Susceptible organisms produce zones of 18 mm or greater, indicating that the tested organism is likely to respond to therapy.
2. Organisms that produce zones of 14 to 17 mm are expected to be susceptible if a high dosage (not to exceed 4 gm per day) is used or if the infection is confined to tissues and fluids (e.g., urine), in which high antibiotic levels are attained.
3. Resistant organisms produce zones of 13 mm or less, indicating that other therapy should be selected.

Organisms should be tested with the ceftriaxone disk, since ceftriaxone has been shown by *in vitro* tests to be active against certain strains found resistant to cephalosporin class disks.

Organisms having zones of less than 18 mm around the cephalothin disk are not necessarily of intermediate susceptibility or resistant to ceftriaxone.

Standardized procedures require use of control organisms. The 30-mcg ceftriaxone disk should give zone diameters between 29 and 35 mm, 22 and 28 mm and 17 and 23 mm for the reference strains *E. coli* ATCC 25922, *S. aureus* ATCC 25923 and *P. aeruginosa* ATCC 27853, respectively.

DILUTION TECHNIQUES: Based on the pharmacokinetic profile of ceftriaxone, a bacterial isolate may be considered susceptible if the MIC value for ceftriaxone is not more than 16 mcg/ml. Organisms are considered resistant to ceftriaxone if the MIC is equal to or greater than 64 mcg/ml. Organisms having an MIC value of less than 64 mcg/ml, but greater than 16 mcg/ml, are expected to be susceptible if a high dosage (not to exceed 4 gm per day) is used or if the infection is confined to tissues and fluids (e.g., urine), in which high antibiotic levels are attained.

E. coli ATCC 25922, *S. aureus* ATCC 25923 and *P. aeruginosa* ATCC 27853 are also the recommended reference strains for controlling ceftriaxone dilution tests. Greater than 95% of MICs for the *E. coli* strain should fall within the range of 0.016 to 0.5 mcg/ml. The range for the *S. aureus* strain should be 1 to 2 mcg/ml, while for the *P. aeruginosa* strain the range should be 8 to 64 mcg/ml.

INDICATIONS AND USAGE: Rocephin is indicated for the treatment of the following infections when caused by susceptible organisms:

LOWER RESPIRATORY TRACT INFECTIONS caused by *Strep. pneumoniae, Streptococcus* species (excluding enterococci), *Staph. aureus, H. influenzae, H. parainfluenzae, Klebsiella* species (including *K. pneumoniae*), *E. coli, E. aerogenes, Proteus mirabilis* and *Serratia marcescens*.

SKIN AND SKIN STRUCTURE INFECTIONS caused by *Staph. aureus, Staph. epidermidis, Streptococcus* species (excluding enterococci), *E. cloacae, Klebsiella* species (including *K. pneumoniae*), *Proteus mirabilis* and *Pseudomonas aeruginosa*.

URINARY TRACT INFECTIONS (complicated and uncomplicated) caused by *E. coli, Proteus mirabilis, Proteus vulgaris, M. morganii* and *Klebsiella* species (including *K. pneumoniae*).

UNCOMPLICATED GONORRHEA (cervical/urethral and rectal) caused by *Neissena gonorrhoeae*, including both penicillinase and nonpenicillinase producing strains.

PELVIC INFLAMMATORY DISEASE caused by *N. gonorrhoeae*.

BACTERIAL SEPTICEMIA caused by *Staph. aureus, Strep. pneumoniae, E. coli, H. influenzae* and *K. pneumoniae*.

BONE AND JOINT INFECTIONS caused by *Staph. aureus, Strep. pneumoniae, Streptococcus* species (excluding enterococci), *E. coli, P. mirabilis, K. pneumoniae* and *Enterobacter* species.

INTRA-ABDOMINAL INFECTIONS caused by *E. coli* and *K. pneumoniae*.

MENINGITIS caused by *H. influenzae, N. meningitidis* and *Strep. pneumoniae*. Ceftriaxone has also been used successfully in a limited number of cases of meningitis and shunt infections caused by *Staph. epidermidis* and *E. coli*.

PROPHYLAXIS: The administration of a single dose of ceftriaxone preoperatively may reduce the incidence of postoperative infections in patients undergoing coronary artery bypass surgery.

Although ceftriaxone has been shown to have been as effective as cefazolin in the prevention of infection following coronary artery bypass surgery, no placebo-controlled trials have been conducted to evaluate any cephalosporin antibiotic in the prevention of infection following coronary artery bypass surgery.

SUSCEPTIBILITY TESTING: Before instituting treatment with Rocephin, appropriate specimens should be obtained for isolation of the causative organism and for determination of its susceptibility to the drug. Therapy may be instituted prior to obtaining results of susceptibility testing.

CONTRAINDICATIONS: Rocephin is contraindicated in patients with known allergy to the cephalosporin class of antibiotics.

WARNINGS: BEFORE THERAPY WITH ROCEPHIN IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS, PENICILLINS OR OTHER DRUGS. THIS PRODUCT SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN SENSITIVE PATIENTS. ANTIBIOTICS SHOULD BE ADMINISTERED WITH CAUTION TO ANY PATIENT WHO HAS DEMONSTRATED SOME FORM OF ALLERGY, PARTICULARLY TO DRUGS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE THE USE OF SUBCUTANEOUS EPINEPHRINE AND OTHER EMERGENCY MEASURES.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad-spectrum antibiotics), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.

ROCEPHIN® (ceftriaxone sodium/Roche)

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind to the toxin *in vitro*.

Mild cases of colitis respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated.

When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: *GENERAL*: Although transient elevations of BUN and serum creatinine have been observed, at the recommended dosages, the nephrotoxic potential of Rocephin is similar to that of other cephalosporins.

Ceftriaxone is excreted via both biliary and renal excretion (see Clinical Pharmacology). Therefore, patients with renal failure normally require no adjustment in dosage when usual doses of Rocephin are administered, but concentrations of drug in the serum should be monitored periodically. If evidence of accumulation exists, dosage should be decreased accordingly.

Dosage adjustments should not be necessary in patients with hepatic dysfunction; however, in patients with both hepatic dysfunction and significant renal disease, Rocephin dosage should not exceed 2 gm daily without close monitoring of serum concentrations.

Alterations in prothrombin times have occurred rarely in patients treated with Rocephin. Patients with impaired vitamin K synthesis or low vitamin K stores (e.g., chronic hepatic disease and malnutrition) may require monitoring of prothrombin time during Rocephin treatment. Vitamin K administration (10 mg weekly) may be necessary if the prothrombin time is prolonged before or during therapy.

Prolonged use of Rocephin may result in overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Rocephin should be prescribed with caution in individuals with a history of gastrointestinal disease, especially colitis.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Carcinogenesis: Considering the maximum duration of treatment and the class of the compound, carcinogenicity studies with ceftriaxone in animals have not been performed. The maximum duration of animal toxicity studies was six months.

Mutagenesis: Genetic toxicology tests included the Ames test, a micronucleus test and a test for chromosomal aberrations in human lymphocytes cultured *in vitro* with ceftriaxone. Ceftriaxone showed no potential for mutagenic activity in these studies.

Impairment of Fertility: Ceftriaxone produced no impairment of fertility when given intravenously to rats at daily doses up to 586 mg/kg/day, approximately 20 times the recommended clinical dose of 2 gm/day.

PREGNANCY: Teratogenic Effects: Pregnancy Category B. Reproductive studies have been performed in mice and rats at doses up to 20 times the usual human dose and have no evidence of embryotoxicity, tetotoxicity or teratogenicity in primates, no embryotoxicity or teratogenicity was demonstrated at a dose approximately three times the human dose.

There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproductive studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nonteratogenic Effects: In rats, in the Segment I (fertility and general reproduction) and Segment III (perinatal and postnatal) studies with intravenously administered ceftriaxone, no adverse effects were noted on various reproductive parameters during gestation and lactation, including postnatal growth, functional behavior and reproductive ability of the offspring, at doses of 586 mg/kg/day or less.

NURSING MOTHERS: Low concentrations of ceftriaxone are excreted in human milk. Caution should be exercised when Rocephin is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness of Rocephin in neonates, infants and children have been established for the dosages described in the Dosage and Administration section.

ADVERSE REACTIONS: Rocephin is generally well tolerated. In clinical trials, the following adverse reactions, which were considered to be related to Rocephin therapy or of uncertain etiology, were observed:

LOCAL REACTIONS—pain, induration or tenderness at the site of injection (1%). Less frequently reported (less than 1%) was phlebitis after IV administration.

HYPERSENSITIVITY—rash (1.7%). Less frequently reported (less than 1%) were pruritus, fever or chills.

HEMATOLOGIC—eosinophilia (6%), thrombocytosis (5.1%) and leukopenia (2.1%). Less frequently reported (less than 1%) were anemia, neutropenia, lymphopenia, thrombocytopenia and prolongation of the prothrombin time.

GASTROINTESTINAL—diarrhea (2.7%). Less frequently reported (less than 1%) were nausea or vomiting, and dysgeusia.

HEPATIC—elevations of SGOT (3.1%) or SGPT (3.3%). Less frequently reported (less than 1%) were elevations of alkaline phosphatase and bilirubin.

RENAL—elevations of the BUN (1.2%). Less frequently reported (less than 1%) were elevations of creatinine and the presence of casts in the urine.

CENTRAL NERVOUS SYSTEM—headache or dizziness were reported occasionally (less than 1%).

GENITOURINARY—moniliasis or vaginitis were reported occasionally (less than 1%).

MISCELLANEOUS—diaphoresis and flushing were reported occasionally (less than 1%).

Other rarely observed adverse reactions (less than 0.1%) include leukocytosis, lymphocytosis, monocytosis, basophilia, a decrease in the prothrombin time, jaundice, glycosuria, hematuria, bronchospasm, serum sickness, abdominal pain, colitis, flatulence, dyspepsia, palpitations and epistaxis.

DOSAGE AND ADMINISTRATION: Rocephin may be administered intravenously or intramuscularly. The usual adult daily dose is 1 to 2 gm given once a day (or in equally divided doses twice a day) depending on the type and severity of the infection. The total daily dose should not exceed 4 grams.

For the treatment of serious miscellaneous infections in children, other than meningitis, the recommended total daily dose is 50 to 75 mg/kg (not to exceed 2 grams), given in divided doses every 12 hours. Generally, Rocephin therapy should be continued for at least two days after the signs and symptoms of infection have disappeared. The usual duration is 4 to 14 days. In complicated infections longer therapy may be required.

In the treatment of meningitis, a daily dose of 100 mg/kg (not to exceed 4 grams), given in divided doses every 12 hours, should be administered with or without a loading dose of 75 mg/kg.

For the treatment of uncomplicated gonococcal infections, a single intramuscular dose of 250 mg is recommended.

For preoperative use (surgical prophylaxis), a single dose of 1 gm administered ½ to 2 hours before surgery is recommended.

When treating infections caused by *Streptococcus pyogenes*, therapy should be continued for at least ten days.

No dosage adjustment is necessary for patients with impairment of renal or hepatic function; however blood levels should be monitored in patients with severe renal impairment (e.g., dialysis patients) and in patients with both renal and hepatic dysfunctions.

HOW SUPPLIED: Rocephin (ceftriaxone sodium/Roche) is supplied as a sterile crystalline powder in glass vials and piggyback bottles. The following packages are available:

Vials containing 250 mg equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1962-01)

Vials containing 500 mg equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1963-01)

Vials containing 1 gm equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1964-01)

Piggyback bottles containing 1 gm equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1964-03)

Vials containing 2 gm equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1965-01)

Piggyback bottles containing 2 gm equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1965-03)

Bulk pharmacy containers, containing 10 gm equivalent of ceftriaxone. Boxes of 1 (NDC 0004-1971-01)

NOT FOR DIRECT ADMINISTRATION.

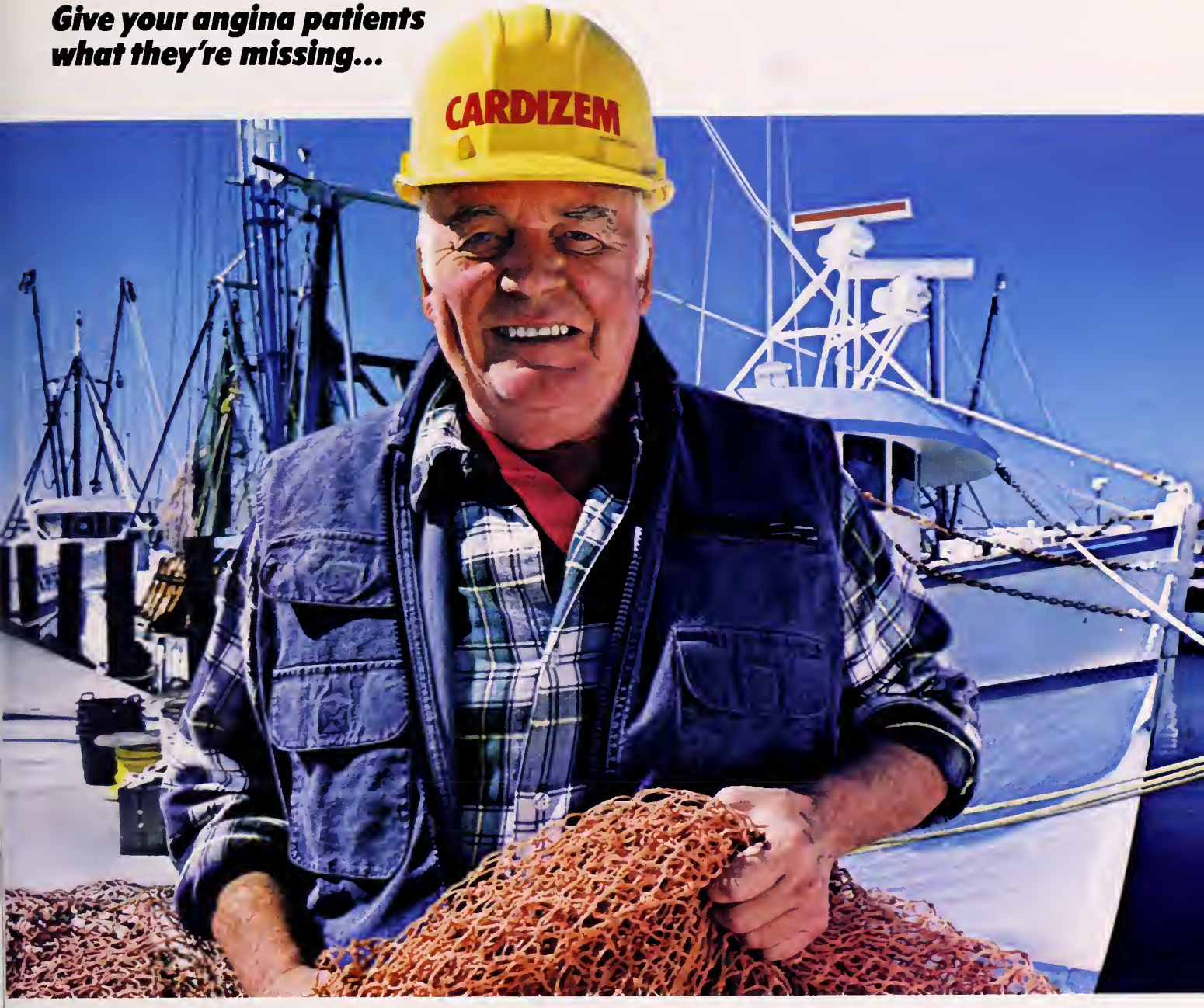
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



References:

1. Data on file, Hoffmann-La Roche Inc.
2. Patel IH, Kaplan SA. *Am J Med* 77:17-25, Oct 19, 1984.
3. Richards DM, *et al*: *Drugs* 27:469-527, 1984
4. Cleeland R, Squires E. *Am J Med* 77:3-11, Oct 19, 1984
5. Tanner DJ, Nazarian MQ: *Am J Med* 77:104-111, Oct 19, 1984

Give your angina patients what they're missing...



CARDIZEM®: FEW SIDE EFFECTS

diltiazem HCl/Marion

- ***Antianginal action includes dilatation of coronary arteries, a decrease in vascular resistance/afterload, and a reduction in heart rate***
- ***Proven efficacy when used alone in angina[1]***
- ***Compatible with other antianginals[2,3*]***
- ***A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD[4,5]***

***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.



CARDIZEM® diltiazem HCl/Marion

FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

60 mg tid or qid

Brief Summary
Professional Use Information

CARDIZEM®
(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients or 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration at doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. ***Issued 7/86***

See complete Professional Use Information before prescribing.

References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* ***3.*** *Johnston DL, Lesaway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982,50(Sept):94-116.*

Another potent benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MO 64137

0246M6



ZOVIRAX®
(acyclovir)
CAPSULES

Prevent genital herpes recurrences month after month with daily therapy.

(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)

Please see last page of this advertisement for brief summary of prescribing information.

ZOVIRAX®
(acyclovir)
CAPSULES

Help free your patients from recurrences.

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks—month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

Please see brief summary of prescribing information on next page.



Prevent recurrences month after month*

ZOVIRAX® (acyclovir) CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance $\leq$10 ml/min/1.73/m^2.

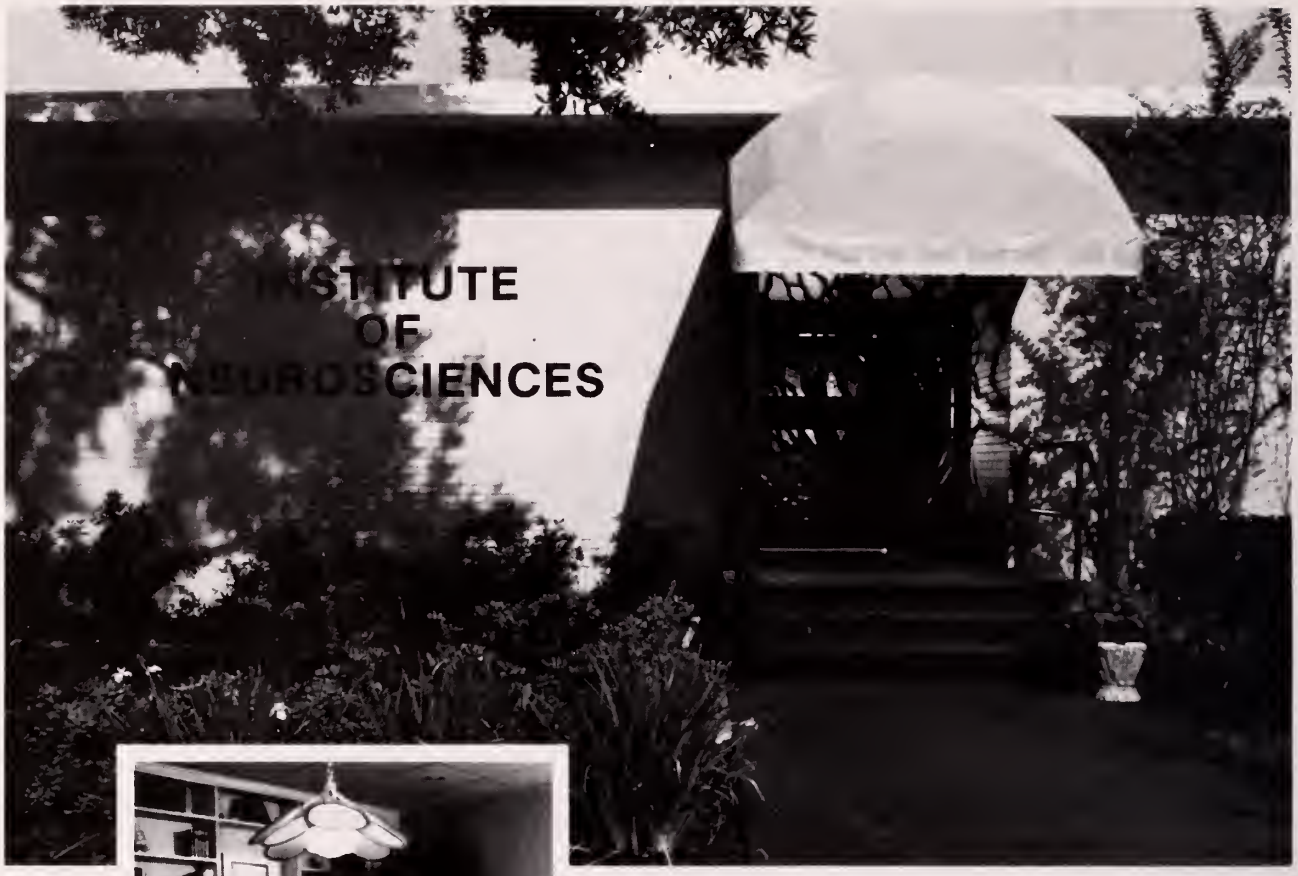
HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200"- Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

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SPECIAL ARTICLE

Primary care and public policy: the Florida experience

Gary J. Clarke, J.D., M.A.

Background • In 1984 the Legislature authorized the Department of Health and Rehabilitative Services to distribute up to $10 million to establish primary care programs "through county public health units . . . based on the need and willingness of counties to participate." No other legislative guidance or direction was provided in this section insisted on by a single powerful member of the Legislature and enacted with relatively little public discussion. The specific enabling provision (Section 409.266(6)(b)F.S.) was considered a minor part of the omnibus Health Care Access Act, which significantly revised Florida's Medicaid program and hospital regulatory environment.

Prior to 1984 there had been little discussion in the State of Florida regarding the importance of primary care or its place in an appropriate and cost effective system of health care, especially in such systems of care for the indigent. A few local health departments had emphasized the provision of primary care and had gained state and even national prominence for their programs (Sarasota, Orange and especially Palm Beach Counties). But overall interest in such programs was relatively weak, as evidenced by the return of the operation of migrant health center programs to federal control in the late 1970s. However, Florida did have the largest concentration of federally funded primary care programs in the Southeast. These community health and migrant health centers accounted for approximately $30 million in federal funds, and 28 centers provided care in 45 sites throughout the state. Nonetheless few had been active in state politics or state legislative decision making at the time of the Health Care Access Act.

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What is primary care? • The literature is replete with definitions of primary care.[1] For instance, David Rogers defines it as " . . . first contact [medicine], comprehensive, ordinarily within a defined geographic area, and for groups of people usually ambulatory and able to function at home." Janeway defines it as ". . . health promotion, identification of individuals at special risk, early detection of serious disease, management of acute emergencies, and the ability to render continuing care. . . ." Several published definitions emphasize "longitudinal responsibility for the patient," "comprehensiveness," "coordination" and "accessibility." The Institute of Medicine definition emphasizes treatment of the whole person rather than a specific illness, and Millis defines it as ". . . all health care needed by a given population that is not provided by secondary or tertiary care." Generally, most policymakers familiar with primary care had identified it as being akin to what the traditional family physician was reputed to have provided to his patients — acute medical care, preventive services, counseling, referral, and general management and oversight of the physical and emotional health care needs of the family.

Specifics of the new Florida primary care program were devised under the guidance of a 25 member committee representing a wide spectrum of consumer and provider groups. Early in its deliberations, it made the distinction between a primary care "service" and a primary care "program." It divined legislative intent that these new funds were to be used to create something new and different than what had previously existed in most county health departments — who were currently providing about $100 million worth of primary care services. As a result, specifications were established for a program that had a number of key requirements. These include:

Medical direction
Emphasis on provision of a "medical home"
Provision of acute care
Provision of preventive services
Eligibility based on federal poverty standards
Eligibility for all family members

24 hour call system
Weekend and evening hours
Coordination with existing primary care providers
Consultation and referral agreements with specialists and hospitals
Cost and productivity standards
Quality assurance requirements

Key to all these requirements was the understanding that the program to be created was to provide a "medical home" for persons who otherwise had no place for regular care. These same persons, it was believed, were likely to be the source of inappropriate hospital emergency room usage and preventable hospitalization. The intended target population was all poor persons either ineligible for Medicaid or, if eligible, those who could find no willing private primary care provider who would accept Medicaid reimbursement.

Provided these general standards were met, the administrative structures that could be devised to accomplish such objectives were diverse. Primary care programs could be mostly contracted out, operated jointly with public and private providers, or operated solely by the health department. Each organizational structure was dependent on local resources and wishes, and was required to be approved by the Board of County Commissioners as well as the district administrator of the state's consolidated human services agency (HRS). However, state level staff made it clear funds would not be provided to areas where existing primary care programs did not demonstrate evidence of cooperation and coordination. From the outset, uniform minimum data were required and an evaluation component was established.

The commitment to fundamental change in the way primary care "services" were delivered in health departments meant that monies could not simply be divided on a formula basis so that counties could do more of what they already were doing. Instead, a sufficiently large chunk of funds needed to be invested to recruit the personnel and equipment necessary to perform new medical, patient management and administrative tasks. As a result, the state Health Program Office issued a "Request for Proposals" to the 67 counties asking if they wished to compete for funds while complying with this new model. Thirty-two counties eventually applied, and contract awards were made to 18 after screening by a large internal review committee.

Recipients of primary care contracts were required to follow the RFP's program guidelines, and actual service delivery began within seven to 14 months after the Legislature enacted the new law. Those counties which subcontracted many of their activities directly to federally funded primary care centers had fewer start-up and recruitment difficulties because these centers already met most of the new state requirements. Table 1 shows those counties currently receiving funds, approximate patient enrollments, number of services provided, and original organizational arrangements.

Why invest in primary care? • The public policy literature is replete with examples of the need for primary care and the lack of public investment in such care. For instance, for more than 20 years health statistics have shown that poor persons are more likely to be sick than wealthier individuals.[2] Despite being sicker, poor persons are less likely to see a physician than well-to-do individuals. Looked at from a slightly different perspective, long standing data show that poor persons are twice as likely to suffer from chronic conditions that can be ameliorated by primary care than middle class individuals.[3]

Differences between the poor and well-to-do are also found in sources of regular care. Poor persons are far more likely to use hospital emergency rooms than middle class individuals, and most frequently cite emergency rooms as their regular source of primary care. In addition, poor persons are far more likely to be hospitalized later in a course of illness, and for a longer period of time than wealthier individuals.[4]

Poor persons are far more likely to use hospital emergency rooms than middle class individuals, and most frequently cite emergency rooms as their regular source of primary care.

Despite this alarming and persistent statistical description of the health care utilization of poor individuals (and associated cost data), there have been few suggestions that direct investments be made in primary care services for the poor. Rather, the overwhelming thrust of American public policy for the past two decades has been to create an "entitlement" program for the poor (Medicaid). The rationale for such an approach was part political compromise and part theory that once entitled the poor could easily purchase needed care on the open competitive market.

Unfortunately hopes for success of the entitlement approach have not been matched by reality. In significant part, this was due to the great variability among the states in AFDC levels to which Medicaid was tied. The huge disparity between AFDC levels in the South and federal poverty levels was particularly noteworthy.[5]

Access to primary care for the poor nationally as measured by number of physician visits did increase marginally after advent of the Medicaid program. However, other differences in such areas as health status, inappropriate use of hospital emergency rooms,

Table 1. — Primary Care Services and Organization Under the Health Care Access Act (1986-7) Projected)

County	Organizational Arrangements	Patients	Services	Funds (mil)
Broward	CPHU/County/Federal	12,344	8,993	$ 1,419
Dade	CPHU/County/Federal	20,000	65,000	1.809
Desoto	CPHU/Hospital	4,066	24,623	.355
Dixie	CPHU/Federal	4,110	16,232	.395
Duval	CPHU/Hospital	14,000	77,500	1.399
Escambia	CPHU/Hospital	5,172	13,965	.299
Hardee	CPHU/Federal	1,815	11,600	.230
Jefferson	CPHU	2,600	9,000	.237
Lafayette	CPHU/Federal	1,850	11,620	.138
Madison	CPHU/Federal	1,700	8,500	.191
Monroe	CPHU/Hospital	6,000	24,000	.350
Orange*	CPHU			.332
Pasco	CPHU	4,860	20,000	.250
Pinellas	CPHU	7,000	24,000	.947
Putnam	CPHU/Federal	6,100	20,4448	.371
Sumter	CPHU/Federal	1,850	7,450	.340
Volusia	CPHU	6,279	34,973	.450
Washington/	CPHU	2,720	9,870	
Holmes**	CPHU	2,968	12,396	.334
TOTALS*** (19)		105,434	440,170	$9.832

* Orange County is a new program.
** Washington/Holmes is a joint project.
*** Totals do not add due to rounding.

Source: Office of the Deputy Assistant Secretary for Health, Department of Health and Rehabilitative Services, Tallahassee.

and delayed and lengthy hospitalization continued to persist.[6] In addition, as costs escalated wildly, greater cost, utilization and paperwork controls were placed on the system, resulting in fewer providers willing to participate. Not surprisingly, especially given the great suburban migratory trends of the population as a whole, fewer and fewer physicians and other providers could be found to treat the poor where they lived (inner city and rural areas), regardless of the financial arrangements made for them. Public and teaching hospitals, with their traditional commitment to the poor, but also their associated high costs and emphasis on inpatient care, remained the great exception to the rule of migration to the suburbs and diminished willingness to treat Medicaid patients.

Problems of encouraging physicians and other primary care providers to participate in the Medicaid program have been nationwide and have persisted almost since its inception.[7] In virtually no state in the country — no matter what its reimbursement rate — have more than 25% of licensed physicians actively participated in the Medicaid program (i.e., billed significantly). Current rates of physician participation in the Florida Medicaid program are shown in Table 2.

In every state in the country instituional reimbursement, particularly for nursing homes and intermediate care facilities, consumes roughly 50% or more of the Medicaid dollar. Most of the remaining Medicaid cost is accounted for by hospital related expenditures.[8] This general pattern holds true in Florida.[9] As shown in Table 3, less than 3% of the entire Florida Medicaid budget is spent for services that indisputably could be classified as primary care.

Beginning with experiments in the late 1960s, the federal government began to broaden its strategy for providing health care to indigents by developing community health (inner city) and migrant health (rural) centers. These primary care centers were developed from the realization that simply entitling individuals did not place a physician where they lived (accessibility), nor did it guarantee that physicians would be willing to serve them (availability). The federal primary care center movement achieved full flower in the 1970s and has held its own throughout the Reagan presidency.[10]

In Florida two thirds or more of all poor persons receiving primary care are not eligible for Medicaid and almost none have private health insurance.

When considered as a health care strategy, the federal primary care program has been weighted with some of the baggage of the Economic Opportunity era

Table 2. — Physician Participation in the Florida Medicaid Program.

Participation Rate
31.8% of all physicians participate
16.1% of all physicians bill ≥ $100
8.1% of all physicians bill ≥ $1,000
3.0% of all pediatricians bill EPSDT
6.0% of all obstetricians participate

Source: Information supplied by the Office of the Deputy Assistant Secretary for Medicaid, Department of Health and Rehabilitative Service, Tallahassee (February 2, 1987).

Projected Medicaid Expenditures: 1986-87 (in millions)

	Expenditures	Percent
Total Projected Expenditures	$1,239.56	100.0
• Physician Services (total)	48.26	3.89
Office Visits (estimated)	15.92	1.28
• EPSDT	9.90	.80
• Family Planning	1.70	.14
• Rural Health Clinics	.94	.08
• ARNP	.24	.02
SUBTOTAL	28.70	2.32
• Outpatient Services	42.29	3.41
• Others: Dental, Visual, Hearing, Day)	7.11	.57
TOTAL	78.10	6.30

Source: Social Services Revenue Estimating Conference — February 27, 1987.

from which it sprang, i.e., competition with private practice, anti-state and local government orientation, mandatory consumer boards, community development aims, etc., which appeared to detract from its essential health care mission. As a result "primary care" never was really embraced by the states as an important part of an overall approach to provide appropriate cost-effective, accessible and available health care to indigents. Instead, tinkering with the Medicaid program and experimentation with various forms of cost control have dominated most state strategies.

Florida's Health Care Access Act of 1984 marked the first time in more than a decade that a state made a new, direct and major investment in primary care. It was also the first time in memory that primary care was viewed as a necessary part of a comprehensive state indigent health care strategy. In essence, the Legislature chose to create a specific primary care capacity rather than to wait for it to evolve in rsponse to entitlement programs. In 1985 Texas followed suit by making primary care an important part of its overall indigent health care strategy, although with a smaller amount of funds.

Is primary care cost effective? ● While intuition and common sense, as well as accepted medical practice, indicate that appropriate, comprehensive and coordinated primary care can identify problems early, institute preventive and ameliorative interventions, forestall or shorten more costly medical and hospital care, and lead to prolonged and more productive life in an individual case, there have been repeated questions about the overall cost-effectiveness of public investments in primary care. These questions have been focused particularly acutely because both the federal investment in primary care as well as Florida's approach have encouraged, but not required direct ties with a comprehensive financial mechanism, i.e., Medicaid. In other words, the question arises: "Are indigent primary care programs still cost effective if the primary care provider is not financially responsible for the total package of care provided to the patient, i.e., hospitalization and specialty care?"

In Florida two thirds or more of all poor persons receiving primary care are not eligible for Medicaid and almost none have private health insurance. Even for those who have Medicaid, there is no requirement that the recipient use the primary care provider (although access and availability are strong positive incentives to do so.) In addition, the public primary care provider is likely to have no more or less direct control over hospitalization than any other private physician in the traditional fee-for-service system. Under these conditions, is it still possible that primary care programs can be shown to be cost effective?

The answer to the question about cost-effectiveness of primary care programs has proved to be a resounding yes. A federally commissioned study of the Denver Neighborhood Health Center, one of the oldest primary care programs in the country, showed that overall health costs per person (all sources) was $267.84 per annum per person compared to $451.82 for a matched group of nonusers[11]. A Boston study of a poor neighborhood near an inner city hospital showed a 41% decrease in admissions one year after the introduction of a primary care center, and a 75% reduction in admissions after two years.[12] The same study showed that those persons with three years of continuous eligibility in the primary care program had only 31% of baseline admissions and 20% of baseline hospital days.

Studies of the Municipal Health Services Program initiated by the Robert Wood Johnson Foundation show similar results. For instance, primary care users had 35% fewer emergency room visits, and 60% lower Medicare and Medicaid costs for emergency room utilization. The same study showed 20%to 40% lower inpatient costs, depending on the type of control group.[13] Studies of the same program by other researchers showed lower overall costs and greater access to primary care.[14].

Finally, the National Association of Community Health Centers summarized over a decade's worth of

research on various primary care centers.[15] These studies found that laboratory, pharmacy and x-ray costs associated with primary care users were two thirds of the national per capita average. With regard to Medicaid pharmacy costs in particular, primary care users accounted for costs that were two and a half times lower than other Medicaid users. Pediatric emergency room utilization was 13% to 38% lower in various primary care sites than for matched groups of indigent children. Overall Medicaid costs for primary care users were 58% lower than non-primary care users who were also Medicaid recipients. This was accounted for primarily by lower hospital admission rates and shorter lengths of stay.

The literature on federal and private primary care initiatives' cost-effectiveness is most pertinent to Florida because the new Florida program adopted most of the essential ingredients of these existing programs. What distinguishes Florida efforts from these federal efforts, and to a lesser extent from the Robert Wood Johnson Foundation program, is primarily organizational requirements. The Florida primary care effort, by statute, requires coordination through local health departments. While accommodating significant hospital involvement (similar to R.W.J.), the Florida program is not operated by private nonprofit entities and is not required to be governed by a consumer-dominated board as are all federal projects. However, all Florida projects must obtain patient/consumer advice and counsel and most have used advisory boards of some type to obtain this input.

The primary care program in Florida . . . was begun in a remarkably short period of time. Within two years after the Legislature enacted the program, and for less than $10 million per year, over 100,000 persons were being reached annually with acute, primary care services not previously available.

Why not invest entirely in Medicaid, especially Medicaid prepaid health plans (HMOs) as a primary care strategy? ● Unfortunately some of the public policy debate in Florida — fueled in part by the impressive research on HMOs and in part by a new corporate/competitive ethic in medicine — can be characterized by an "either primary care or HMOs" mentality. In truth both strategies offer potential advantages, neither are directly competitive, and both represent parts of what needs to be a balanced and comprehensive strategy to provide needed health care to indigent patients. Both strategies offer significant theoretical advantages for more accessible, cost effective and appropriate care. They do, however, have different organizational and financial imperatives, different time periods for implementation, different measures of success, and somewhat different target groups of patients.

The primary care program in Florida was begun in a remarkably short period of time. Within two years after the Legislature enacted the program, and for less than $10 million per year, over 100,000 persons were being reached annually with acute primary care services not previously available. In contrast, Florida, Iowa, New Jersey, North Carolina, South Carolina and a host of other states who hoped to quickly and greatly expand their Medicaid populations in the past two years (under provisions of the federal Deficit Reduction Act of 1984 and state statutes such as the Health Care Access Act), have been sorely disappointed.[16] Tiny enrollments have taken place in all these states — in Florida, for instance, 2,000 pregnant women versus an estimated 51,000 — despite the availability of literally hundreds of millions of dollars.

A more graphic example is provided by the fact that more money has been spent on administrative costs to get approximately 10,000 individuals qualified for the expanded Florida Medicaid program than has been spent on the entire primary care program. This appears to be due primarily to stringent federal, and particularly state-imposed AFDC assets and income requirements to which Medicaid is inextricably tied by federal law. The primary care program by contrast, set eligibility at 100% of the federally defined poverty level, and required no assets test or extensive eligibility forms. Current Florida Medicaid eligibility requirements are roughly 33% to 44% of the federal poverty level, have stringent assets tests ($1,700), extensive documentation requirements, and will cover only certain "categorical" groups regardless of medical need.

The problem with a "Medicaid only" approach to indigent care is the large numbers of poor individuals needing access to health care who will never be eligible for Medicaid because of categorical requirements, e.g., intact families, single adults, or assets requirements. These families still need a willing provider and, if their primary care needs are not met, will still result in inappropriate and expensive hospital use that is unlikely to be paid for. One of the most disturbing findings of the evaluation of Arizona's experiment with statewide Medicaid prepaid health plans was the sharp reduction in care provided to the indigent population not technically eligible for Medicaid. This group's number of physician visits and access to a regular source of care fell sigificantly (20% - 70%) after implementation of the new program.[17] This resulted from the greatly heightened emphasis on Medicaid eligibility as the sole indicator of whether primary care should be provided or not. Current Florida primary care programs offer the advantage of not only quick productivity, but flexibility to provide needed, relatively inexpensive care without the constant

threat of Medicaid disallowances. Persons with no insurance or access to primary care are far more a threat to cause unpaid hospital bills than Medicaid patients.

The greater flexibility of the Florida primary care programs is particularly helpful as these programs move to create or combine themselves with other entities to create Medicaid prepaid health plans. Where primary care funds are joined with a prepaid health plan, the frequent difficulties with "on and off" eligibility for the Medicaid program need not create discontinuities in a managed continuum of primary care for the patient. Interestingly, the majority of enrollees in Florida's current Medicaid prepaid health plans are represented by programs in four counties where primary care funds are or will be combined with Medicaid funds (Dade, Duval, Munroe and Palm Beach Counties). It should be noted that a major objective of the Florida primary care program is not only to begin providing primary care services immediately, but also to build the outpatient arm for eventual linkages with secondary and tertiary providers into a comprehensive managed system.

Despite their inherent theoretical appeal, the difficulties of creating prepaid, managed systems of comprehensive health care cannot be underestimated. A number of privately financed HMOs aimed at middle class markets in the past decade have failed.[18] With lower rates, generally sicker patients, and greater mobility (as measured by likelihood of continuing to be eligible for the program), a number of state and federal attempts to establish widespread participation in Medicaid prepaid health plans have been disappointing. Although there are indications of significant improvements in the success rate of Medicaid HMOs, providing health care to the poor is a difficult and expensive business that has not attracted significant venture capital — and few if any of the well-established middle class oriented HMOs. Nevertheless, there are now 159 separate Medicaid prepaid health plans throughout the country.[19]

Primary care funding should not be viewed as competitive with a strategy to expand Medicaid or establish more Medicaid prepaid health plans.

A number of prepaid health plans for the poor have been rocked with charges of fraud, mismanagement, failure to provide services, and a host of other ailments. See, for instance, the California Medicaid experience in the early 1970s, and the mixed results of Arizona's experience.[19] In retrospect, many of these experiments seemed doomed from the start given the speed with which government launched relatively massive efforts, lack of attention to quality control and provider management, medical and fiscal capability, and relatively low rates (compared to middle class oriented HMOs) government was willing to pay. In addition, here is some (surprising) evidence from the Rand studies that low income groups actually fare less well in an HMO than in a fee-for-service system.[20]

However, California has now enrolled over 250,000 Medicaid recipients in various prepaid plans, and few problems are reported there or in other states like Florida.

While private capital and enterprise is welcomed, most analysts of Medicaid prepaid plans believe that without very large boosts in rates, such plans are more likely to succeed only if technical assistance and public investment is targeted at those groups (whether public or private) likely to perceive their organization as having an important role in providing for the health care of poor persons. Publicly funded primary care providers and hospitals providing large amounts of indigent care have proved to be two of the most natural allies in creating larger managed prepaid Medicaid systems in Florida and elsewhere around the country.

Primary care funding should not be viewed as competitive with a strategy to expand Medicaid or establish more Medicaid prepaid health plans. Rather primary care funding has the net effect of:

1. Creating an immediate presence of a willing and able primary care provider for Medicaid and other poor patients (the latter group in Florida is three times larger than the Medicaid population), who would otherwise use the hospital inappropriately; and
2. Setting the stage for large combined efforts of inpatient and outpatient programs, whose mutual Medicaid clients would benefit from being enrolled in a comprehensive prepaid Medicaid program.

Finally, as discussed earlier, the Medicaid program covers only a small portion of those in our society generally termed as poor. In 1984 the Florida Medicaid program included about 24% of the poverty population as eligible recipients — a ranking of 42nd in the country, tied with Alabama.[21] There are still large numbers of persons in need of primary care, many of whom may unnecessarily contribute to the bad debt and indigent care burden of hospitals, who will not receive such care under any Medicaid fee increase. An expansion in a primary care capacity for all poor persons, when combined with a feee increase that makes Medicaid fees at least reasonable, if not strictly competitive, seems the best strategy to begin a safety net of primary care programs throughout the state that rely on public and private sector input.

Why establish primary care programs "through" county health departments?● Of all the policy

questions surrounding the primary care debate in Florida, this has been the most recurrent. Federally-funded primary care centers were angered they had not been specifically mentioned in the new legislation. A number of Medicaid analysts felt the program should have been geared exclusively to Medicaid recipients, and that health departments should have been but one of a number of possible providers of primary care. Some private practitioners believed the public health focus was misplaced. A number of county commissioners believed money should flow directly to the commission itself for further division rather than through the county health department. Even some local health department directors were upset by the new program, believing funds should have been allocated on a formula basis and that few of the new requirements or conditions should have been established.

Despite these problems there was sound rationale for using Florida's public health systems as a basis for creating a statewide primary care capacity. First, unlike a number of states, there is a bona fide presence of a health department providing some type of primary care service in every county in the state. Second, health departments are tied together with a uniform reporting and budget system, uniform medical and nursing protocols, and a host of other systems, to both county commissions and the state. Third, while still locally responsive organizations, there is significant state control of all county health departments in Florida, by reason of tradition, funding and significant statutory changes in 1983. For instance, all county health department employees are state employees, and the director of each department is appointed by the Secretary of HRS with the advice and consent of the county commission. Thus, health departments offer a structure in every county in the state which both state and local officials can build on.

Why aren't Medicaid fee increases alone sufficient to encourage the provision of all necessary primary care?

• While the need for primary care services for poor persons in general, and Medicaid recipients in particularly has been evident for some time, there have been differences in opinion over how to increase such services. Some analysts believe that significant fee increases for primary care services in the Medicaid program will induce sufficient private provider participation in the Medicaid program to make further general revenue increases in primary care unnecessary. Like with the Medicaid prepaid health plan debate, it appears a mistake to see these strategies as mutually antagonistic or duplicative rather than complimentary.

Past experience with the Medicaid program nationwide indicates that simple increases in Medicaid fees are generally not determinative of significant provider partcipation in the program. Several analysts believe that paperwork and eligibility requirements associated with the Medicaid program are as important stumbling blocks to provider participation as the monetary amount of the fee itself. In addition, experience in many states has shown that once providers cease significant participation in the Medicaid program they are unlikely to participate again — regardless of marginally sweetened financial incentives or reduced bureaucratic requirements. Finally, individually identified provider fee increases are easy political targets as government budgets are tightened and, generally speaking, are not likely to keep pace with private developments.

While these problems are discouraging, they should not lead to despair on this issue. Significant fee increases should result in keeping current Medicaid providers within the fold as important providers of care. In addition, organizations that specifically target indigent populations should benefit by receiving enough revenue to at least cover their costs. For instance, the current Florida Medicaid reimbursement rate for comprehensive prenatal care ($62) does not even cover hourly costs and supplies of a nurse midwife (minimum of five visits) much less the costs of time and supplies if those services were provided by a physician.

It should be kept in mind that changes in the supply of physicians and the variety of organizational arrangements for providing care may lead to different results in the late 1980s and beyond. Nonetheless, even a doubling in current Medicaid rates for comprehensive obstetrical care (from $300 to $600) is unlikely to result in dramatic changes in the physician marketplace when the current rate for middle class patients is $1,400-$2,000. Even more important, a greater willingness to see Medicaid patients is not likely to be accompanied by a shift in private office space to inner city or rural areas.

The current investment in county health departments in Florida and their unique mission and local nature made them an ideal vehicle to begin a statewide primary care program.

A fourth rationale for the use of county health departments was the huge, if relatively unknown, investment in primary care already being made in health departments by the state and local governments. (Table 4) At the time of the Health Care Access Act, approximately $100 million worth of primary care services could be identified as being offered in heatlh departments throughout the state. Admittedly, a good deal of this care was disjointed by various federal and state requirements. In addition, few health departments had the ability to provide acute care, (i.e., physicians on staff or under contract), for pa-

Table 4. Significant Primary Care Services Provided by County Public Health Units, 1985-86 Actual

Type of Service	Patients	Services	Expenditures
Family Planning	132,819	579,525	$15,122,749
Improved Pregnancy	35,940	620,433	20,769,082
Child Health	177,699	822,385	17,282,416
Immunizations (Child)	292,769	873,299	5,180,811
Chronic Disease (Adults)	219,862	563,485	9,123,337
Women, Infants and Children (WIC)*	189,358	568,512	9,847,582
Dental Care	365,403	581,376	7,587,913
SUBTOTALS	1,413,850	4,040,503	$84,913,886
Primary Care**	103,284	588,021	17,008,310
TOTALS***	1,507,134	4,628,524	$101,922,196

* Only nutritional and administrative expenses; $40 million in food dollars considered state expense
** Includes county and federal funds; state program not operating entire year in all 18 counties
*** Not unduplicated; clients unduplicated within programs but may be enrolled in more than one program; STD and TB services not included

Source: Office of the Deputy Assistant Secretary for Health, Department of Health and Rehabilitative Services, Tallahassee. Report OFC007 (February 12, 1987)

tients seen in a variety of these preventive and personal health programs. Nonetheless, health departments represent a well-known place for mostly poor persons to receive care, (over one million persons visit health departments each year in Florida).

In addition to offering a number of primary care programs generally using 100% of poverty as the eligibility guideline, with a sliding fee scale above that amount, health departments are the main providers of certain Medicaid services in Florida. For instance, most EPSDT screenings (estimate 90%) and most Medicaid family planning expenditures (estimated 75% are accounted for by Florida's county health departments. And health departments are estimated to provide prenatal care to about one half of all pregnant Medicaid recipients.

Thus, despite some of their traditional antipathy toward providing acute care, and despite hesitation about investing a new program in an institution not always well regarded for creativity or responsiveness, running a primary care program through county health departments was the only institution to be found at the local level whose very mission was to be concerned about the health of the entire community. It was responsive to both state and local governments, it already served large numbers of poor persons, and it already represented a large investment of state (70%) and local (30%) resources in primary care services. The administrative task was to convince public health officials their mission was more than the control of communicable disease and to modernize their systems for dealing with the business of modern, acute care medicine.

In large part the task has been approached through a combination of bargaining and administrative requirements. The bargaining approach has required counties, as a condition for receipt of funds, to negotiate and include in their primary care system other willing providers. In other words, the mission of the health department is to assure, within the resources necessary, that primary care is provided and coordinated — and not necessarily for the health department itself to provide all aspects of that care. Indeed, state officials see this as the fundamental mission of public health — surveillance, coordination, and community advocacy — and believe that the method of accomplishing the task is driven by an analysis of cost, acceptability, availability and quality, not by "who's in charge." As a result, about 40% of all primary care funds distributed thus far have been subcontracted with a variety of private providers. Federally funded and county funded primary care centers have received the lion's share of these funds.

The health department was the only institution to be found at the local level whose very mission was to be concerned about the health of the entire community.

The administrative requirements detailed earlier in this paper have forced the health departments to turn their attention to nontraditional public health concerns such as Medicaid eligibility, billing and collection, diversion of inappropriate emergency room utilization, and hospital admissions. The emphasis on medical direction and staffing has resulted in a "coming together" of a number of existing public health programs that reinforce the preventive nature of those programs and force a new emphasis on quality. The emphasis on quality has been highlighted

by a state goal of national accreditation for each primary care program within five years.

In summary, the current investment in county health departments in Florida and their unique mission and local nature made them an ideal vehicle to begin a statewide primary care program. Administrative and philosophical difficulties with this approach should not be underestimated, but the promise of maximization of existing resources, adaption to local conditions, and creation of an advocate for access to the health care system cannot be denied.

Does continued investment in primary care through county public health units make sense in Florida? ● It has been said that while the new primary care program has reached only 18 counties, it is the only success story of the service expansions mandated under the Health Care Access Act. Ten times the number of individuals seen under the expanded Medicaid categories have been seen in the primary care program. Yet even today a number of analysts are discussing still further expansions to Medicaid, costing literally hundreds of millions of dollars, yet ignoring the only successful program to date actually serving individuals — one that costs one twentieth as much as these new proposals.

The true measure of success of a primary care program, however, is not just how many individuals it sees, but further outcomes on the health, and cost of health care, of the citizenry. To determine these outcomes, an evaluation was considered an integral part of this program and funded from its beginnings. The task was a difficult one: to prove cost-effectiveness in a program that adopted a variety of administrative mechanisms, that served Medicaid and non-Medicaid patients alike, and that represented a major philosophical and administrative change in many public health programs. Despite the impressive data from other studies, many policy analysts were unconvinced that primary care — at least as formulated and implemented in Florida — would work, despite its great similarities to other national programs.

By January 1987 evaluative information was just beginning to come in. Decisions to award primary care funds were made by the Secretary of HRS beginning in January 1985. Actual program operations began in March and later that year depending on the notice cycle, negotiations with county commissions, and the time necessary to hire additional staff. Most projects began operation in the middle of 1985 and did not achieve full stride until a year later. Thus data available today on the 18 new primary care projects generally represent no more than a year to a year and a half of operation, and includes in it the time period for beginning operations, including purchasing equipment, making renovations, routinizing procedures for intake, eligibility, referrals, and establishing all medical protocols.

While admittedly scanty, the evidence to date on the impact of the Florida primary care program is suggestive that these programs are reducing the health care costs of Medicaid recipients and diverting emergency room usage. In addition, there is considerable anecdotal evidence that the primary care investment has been successful in its goal of building larger networks of providers willing to serve indigent patients.[22]

Medicaid cost data was derived from primary care clients who were also Medicaid recipients in five counties as well as from a matched group of Medicaid patients in the same counties who were not enrolled in primary care programs. The comparison showed that overall Medicaid costs were more than 20% lower for the primary care Medicaid recipients than the matched group — a savings of $168 per year per client.[23]

While admittedly scanty, the evidence to date on the impact of the Florida primary care program is suggestive that these programs are reducing the health care costs of Medicaid recipients and diverting emergency room usage.

A review of "after hours" call logs of the primary care programs was conducted to determine perceived impact on emergency room usage/diversion. In every site, one half or more of all calls were handled without requiring referral to an emergency room, although a large percentage (up to 60% in two counties) were later required to be seen by a physician at the primary care site.[24]

Additional data are still being gathered on the program to compare physician visits, hospital admissions, length of stay, patient satisfaction and other factors. Although showing an expected variability by county, the information gathered thus far is consistent with national studies on the subject. In addition, national studies indicate that differences between control groups may be more marked after the program has passed its infancy and served as a regular medical home for a period of time. In fact, the federal government does not even conduct an evaluative review of its nascent primary care programs until they reach their third year.

Other information on successes of the state's primary care program is anecdotal. In several of the rural counties, the primary care program has funded the first and only primary care physician willing to accept Medicaid patients in the entire county. In Volusia County, the health department has developed relationships with all three hospital districts for

coverage, mutual referral of patients, and staff privileges. In that same county, the health department and Children's Medical Services are co-locating in a single facility to ease patient referral and promote ease of access for families. In Broward and Dade Counties, the "primary care program" is actually a consortium of federally funded primary care centers, county funded primary care programs, and the two health departments. In both counties the three groups are working with the large public hospitals to develop an automated uniform eligibility and referral process. In Munroe County, the initial success of the subcontract with the local hospital has led that hospital to jump into the Medicaid prepaid health plan business. And in Duval County, primary care funds have been used to provide the physician and other health care professionals staffing necessary to turn eight health department clinics into the outpatient arm of University Hospital's Medicaid prepaid health plan. Patients seen in these clinics include not just Medicaid clients, but all poor persons with incomes up to 100% of the poverty line.

In summary, at a time when the state is considering investing $200 million to $500 million in indigent health care, a comprehensive primary care capacity has been established in less than a third of Florida's counties for 2% to 5% percent of those totals. Increasing entitlement guarantees have not, by themselves, generally been as successful as hoped in establishing a cost effective system of health care for indigent persons. An additional $20 million investment in primary care seems a proven and necessary ingredient of any balanced statewide strategy to solve the indigent health care problem.

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● Mr. Clark, Department of Health and Rehabilitative Services, 1317 Winewood Boulevard, Building 1, Room 115, Tallahassee, 32399-0700.

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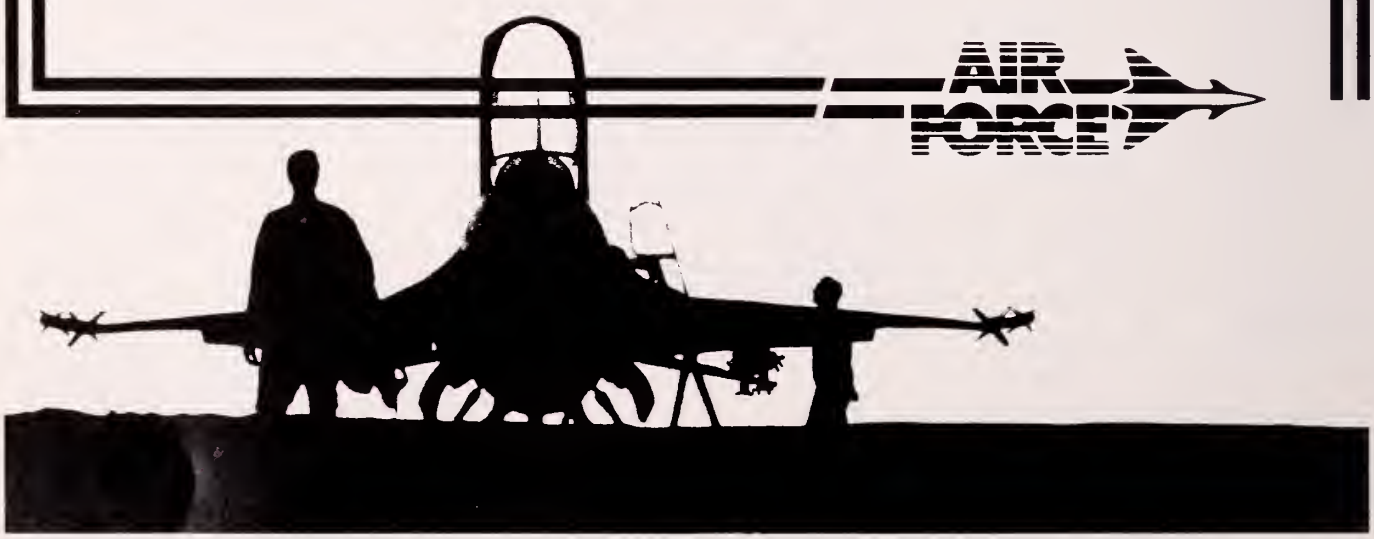
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NOTES & NEWS

USF to honor the late Dr. Bolivar

The University of South Florida College of Medicine, through Richard G. Connar, M.D., Chairman of the Department of Surgery, has launched a drive to honor the memory of the late Dr. Juan C. Bolivar by creating and dedicating at the University the Juan C. Bolivar Chair of Oncologic Surgery.

Dr. Bolivar, a renowned cancer surgeon who trained both at the University of Havana and Sorbonne in France, came to the United States in 1959 and eventually became a Professor of Surgery at the University of South Florida College of Medicine and the first Director of Surgical Oncology at the school. He did extensive research in surgical oncology, published 79 papers in renowned surgical journals, and received Humanitarian Service by the AMA and an appointment by the U.S. Department of State to train young surgeons for the Army during the Vietnam War. Posthumously he also received, through his widow, Yolanda, the highest award given by the President of France — member of the Legion of Honor.

An estimated $1 million will be needed for the establishment of the chair. Donations can be sent to Dr. Richard G. Connar, University of South Florida Foundation, Juan Bolivar Chair, Tampa, Florida.

Dr. McCollough elected second vice president of national orthopaedic association

Newton C. McCollough III, M.D., Director of Medical Affairs, Shriners Hospitals for Crippled Children, Tampa, was elected second vice president of the American Academy of Orthopaedic Surgeons (AAOS) at the organization's annual meeting, January 22-27, in San Francisco. As second vice president this year, he will become president of the Academy in 1989. With 13,276 members nationwide, the Academy is the largest medical association for musculoskeletal specialists in the world.

As director of medical affairs for Shriners Hospitals for Crippled Children, McCollough oversees all medical activities of the 22 Shriners Hospitals located throughout the United States, Canada and Mexico, where all medical care and services are provided to children under the age of 18 free of charge. Nineteen of the hospitals are dedicated to treating orthopedic problems in children, and the three Shriners Burns Institutes provide care for severely burned children.

In addition to his position at Shriners, Dr. McCollough is a Professor in the Departrment of Orthopedic Surgery at the University of South Florida, Tampa, and serves as an orthopedic consultant to Jackson Memorial Hospital, Miami; Shriners Hospital for Crippled Children, Tampa unit; and the Bureau of Crippled Children, State of Florida.

A native of Butler, Penn., Dr. McCollough earned his B.A. From Duke University and his M.D. from the University of Pennsylvania. His internship and residency training were at Jackson Memorial Hospital and Variety Children's Hospital, both in Miami. From 1978 to 1986, he served as Chief of Orthopedics, Jackson Memorial Hospital, and as Professor and Chairman of the Department of Orthopedics and Rehabilitation, University of Miami School of Medicine.

He was a Lieutenant Commander, Medical Corp, U.S. Naval Reserve from 1966 to 1968, and was awarded the Legion of Merit with Combat V while serving with the 3rd Marine Division in Vietnam.

Active in a variety of AAOS activities since becoming a member in 1970, Dr. McCollough is chairman of the Academy's Coordinating Committee on Education and the Task Force on Interactive Video-Education. He is a member of 18 medical associations including the FMA and is treasurer of the 20th Century Orthopaedic Association, a member of the Council of Musculoskeletal Specialty Societies, and Past President of the Pediatric Orthopaedic Society of North America.

McCollough is the author of numerous scientific articles, and he lectures extensively. His achievements have been recognized in "Who's Who in America" since 1982.

McCollough and his wife, Mary, have two children.

Call for entries: 1987 ASCP medical photography competition

Health care professionals who are interested in medical photography are invited to enter the Annual American Society of Clinical Pathologists Medical Photography Competition, sponsored by Nikon, Inc. Up to three entries may be submitted in each of three

categories: gross or macroscopic; microscopic; and electron microscopic.

The purpose of the Competition is to encourage and recognize excellence in the field of medical photography. Each entry will be judged on its scientific merit, content, composition, quality of image, and originality.

The following prizes will be awarded in each of the three categories: 1st prize-$500; 2nd prize-$300; 3rd prize-$150; and two honorable mention awards-$50. Certificates of merit will be awarded to all entries that meet a minimum standard of photographic excellence.

Winning entries will be displayed at the 1987 ASCP/CAP Fall Meeting in New Orleans, and will be published in the official ASCP journal, Laboratory Medicine.

The ASCP and Nikon, Inc., will sponsor, judge, and produce the 1987 Medical Photography Competition. Entries must be submitted no later than June 1. Official entry forms are available from the ASCP, 2100 W. Harrison St., Chicago, IL. Attn: Medical Photography Competition, or toll-free 1-800-621-4142 (In Illinois: (312) 738-4890).

The ASCP also offers Nikon's free tip sheet on photomicrography — "Five easy steps to set up for photomicrography."

DEAN'S MESSAGE

Medicine from a student's perspective

Robert A. Skidmore Jr.

The role of a physician is determined not only by the medical education received, but by the interaction which occurs between the physician and the community. The physician is continually viewed as a leader and the champion of health. A physician is not only a member of an office, clinic, or hospital staff, but also a member of the community. Yet in recent years, with the drive of those to change medicine into a trade and reduce the physician's role to that of a technician, the interaction of the physician in the community has become a dying flame rather than the central fire which brought the community and physician to common ground.

During my four years of medical education, I will study lecture notes, books, patient's and medical journals in an effort to build a base of knowledge to assist in the evaluation, education, and treatment of patients. I will develop and hone clinical skills and competence which will guide me toward a diagnosis, again for the good of the patients. The four years will not prepare me for a life as a skilled technician, but only introduce me to the art of medicine. Here, a void is seen between the narrow interaction with a few patients and the larger duty of a physician to be the community's champion of health and well being.

The art of medicine is the way a physician interacts with the patient, the hospital team, and the community. This interaction provides the basis for understanding between the physician and those with whom the physician works. This understanding is what is so desperately needed in today's medical climate. The community is uncertain of the physician's role. The community has, in recent years, only seen the misguided drive of certain people to change the art of medicine to the trade of medicine. The best way to bring the physician and the community to a new understanding of the physician's role in society is for the physician to increase the interaction between organized medicine and the community.

The medical students must also understand that the duties of a physician do not stop at the door of the office, clinic, or hospital but continue out into the community. The only way for the medical students to be introduced to this aspect of interaction is to work with the community and realize the profound effect that the interaction can produce. The Florida Medical Association, recognizing the needed experience which medical students could obtain from working with physicians who are actively involved with the community, established a Medical Student Section in September 1986. The Florida Medical Association Board of Governors approved the constitution of the newly formed Medical Student Section in January of this year. The organization of the medical students on a local level has continued for two years and is now on solid ground, ready to work.

The Florida Medical Association and County Medical Societies have a need to increase the interaction between physicians and the community; to reinforce the role of the physician. The understanding which shall come from this interaction will assist in the resolution of the image problem physicians are facing. The medical students are organized, energized and have a strong desire to get involved and complete the introduction to the art of medicine. I ask the Florida Medical Association and County Medical Societies to look on the Medical Student Section as a resource of manpower, ideas, and energy. Through the partnership that has been formed, the goals of physicians and medical students can be achieved. Yet of more importance, the widening gap between the community and the medical profession can be closed and a new era of understanding and involvement can begin.

Mr. Skidmore is a student delegate to the Florida Medical Association and the American Medical Association and a member of the Class of 1989 at the University of Florida College of Medicine.

ENCORES!

I am afraid

As a surgical specialist in Dade County who will not be taking call in emergency rooms for the present time, I, for one, would like to tell you everything.

I have been practicing cardiothoracic surgery in Dade County for over 17 years. I have served my patients, my hospitals and my community well, both inside and outside of medicine. Why, all of a sudden, do I turn into a non-caring, irresponsible, money hungry monster almost overnight? The answer is simple: I am afraid, really afraid to care for unassigned patients in an emergency setting.

I'm afraid that, despite my best efforts, caring for an injured person whom I have never seen before will find me on the wrong end of a lawsuit. I worry that this lawsuit will result in a judgment against me far beyond the limits of the insurance coverage that I can afford. I am worried that I will be blamed for a bad result despite my best efforts in a situation over which I have little control.

I am pursuing the American dream just like everybody else, trying to educate my children, planning for the future, looking forward to leisure time, and eventually retirement, and I am afraid that some huge lawsuit will come crashing down on my head and my future will come crashing with it. I am afraid that I might have to pay $25,000 or $50,000 a year to some family for the next 20 years trying to save a life that can't be saved.

I am afraid that the emergency room is calling every time my beeper rings. My stomach gets knotted up as I wonder, "Is this the case that is going to do me in? Is there a million dollar lawsuit lying on the stretcher with this injured person?" Try some of these fears on for size and maybe the physicians' side of this problem can be appreciated.

The present emergency room crisis is so reminiscent of a similar situation that occurred in Dade County 10 or 12 years ago. It came to public attention that physicians, and other non-professional citizens, were being sued as a result of their stopping to aid automobile crash victims at the accident scene. Then, as now, physicians were accused of all manner of malpractice, from not accompanying victims all the way to the emergency room, not giving complete reports to the receiving physicians, to not splintering fractures just right, and on and on.

So what happened as a result of these accusations and suits? Doctors, and everybody else, no longer stopped at accidents; they just kept driving by. The legal community laid blame on the physicians; "If these doctors would learn how to take care of an accident victim correctly, there wouldn't be any need for these lawsuits." The doctors were flayed publicly as being uncaring, irresponsible, not adhering to the Hippocratic Oath. Sound familiar? Well, citizens were upset by this chain of events and a great public cry went up. Legislators responded to this crisis by expanding the Good Samaritan laws in Florida to allow everyone, physicians and lay persons alike, to follow their conscience by coming to the aid of the injured. This present situation is just more of the same.

Be assured that I have no desire to shed my duties and obligations to my patients, other doctors' patients, the hospitals that I serve or the public in general. I feel deeply the need to live up to the public trust placed in me as a physician. I would, in one second, retract all of the letters I wrote two weeks ago resigning from emergency room call if I could be protected from lawsuits beyond my coverage when performing public service.

I care not whether the accident victim is able to pay me one dime; I just don't want my whole future to blow up in my face while attempting to help him. But this present crisis is real and must be addressed. Rep. Art Simon's inaccurate notions to the contrary, over half of all malpractice suits filed against general, thoracic and neurologic surgeons have their origins in the emergency room. I agree, however, that making a connection between the emergency room crisis and rising malpractice insurance rates is very tenuous.

On the other hand, modern medicine is *not* a marketplace. The public should disabuse themselves of the idea that caring for the sick and injured is primarily a business. Physicians, as well as other health professionals, are steeped in a tradition of caring and compassion. We desire desperately to fulfill this role the public demands of us with a clear conscience, and without fear of punitive reprisal. At the risk of unwisely proposing a simple solution to a complex problem, perhaps we should look back at the Good Samaritan days for a permanent solution to the present emergency room crisis.

Richard M. Rubinson, M.D.

Reprinted with permission from *Miami Medicine*, February 1987.

Perverse myth

The causes of the liability crisis are probably multifactorial but some of the most frequently mentioned are the contingency fee system, the number of attorneys, a litigious society with a lottery mentality, high public expectations and the permissive judges and juries. These all relate to the

legal system. More worrisome, however, is the pervasive charge that the cause is really due to all the "bad doctors" out there.

It is continually alleged that the problem is doctor incompetency. If only the self-serving medical profession would review itself and weed out the bad doctors, then the problem would be solved. "Clean up your own act" is the admonition.

The *Orlando Sentinel* published their data that 50% of the dollar settlements were from 10% of the doctors in support of their opinion that there really was a "bad doctor" problem. Yet doctors look around and see highly trained and motivated colleagues rendering excellent medical care day in and day out. Where are all the incompetent doctors? Analyzed another way, we could say that 100% of the claims are the result of 33% of the physicians. A minority to be sure, but if one-third of the doctors were incompetent, then we have a medical crisis of the greatest dimension and that crisis should be obvious to everyone. A recent AMA survey showed that nationally 68% of the physicians currently practicing have been sued and surely that number is much higher in Florida. Most of these have come in the last ten years. At the current rate of suits then, there is a near certainty that virtually all will have suits filed against them.

It was the keen intellect of Insurance Commissioner, Bill Gunter, that led him to conclude that "the cause of the malpractice crisis is malpractice." That apparently passed for clever rhetoric wisdom in Tallahassee. In fact, virtually every day all physicians in some aspect fall below a theoretically ideal standard of practice. In almost every instance of a complication of diagnosis or treatment an alternative would have been possible, and you can be certain that someone will testify that you should have used that alternative. With every perscription you write — did you inform that patient of all the possible side effects? What if a one-in-a-thousand major side effect should occur?

The point is that while human beings are involved, we will always have adverse outcomes and human errors. Where in the system is that allowance for human frailty.

If "bad doctors" were the problem, then paradoxes literally cry out for answers:

1. Why is medical care getting better by every index, while numbers of suits goes up?
2. Why are there more "bad doctors" in Florida than in Indiana, for instance?
3. Why are there more suits in the specialties that require some of the longest and most intensive training, such as plastic surgery, neurosurgery, cardiac surgery and obstetrics?
4. Why does America have the worst doctors in the world as indicated by the number of suits, yet the best health care?
5. Why is it that the best students enter medicine and then turn out to be the least competent?
6. Doesn't medical education require a whole sale change if they continue to turn out "bad doctors?"

Examined from any point of view, the "bad doctor" hypothesis can't be supported. Oh, there are individuals who are less careful, less knowledgeable, less competent, less well-trained than others, and there are probably a few who skip by the checks of the system and might be labeled a "bad doctor." Those are very few, however. We do need intensive peer review and quality assurance but bad doctors have not caused the liability crisis. Let's put that hypothesis to rest.

Ralph E. Rydell, M.D.
Tampa

Reprinted with permission from the President's Page, *Hillsborough County Medical Association Bulletin*, March 1987.

To us we throw the torch

The other day, while getting my car super-lubed, I suddenly realized that this newsletter, now entering its third year in slick format, has not yet addressed the issue of Civilization.

What an astonishing oversight, I thought, as they squirted grease into my underpinnings. Since three or four of the advertised ten minutes in which this ritual is performed had passed, I had a scant but delightful six minutes of profound leisure to consider the Civilization question before being once again propelled into the hectic mainstream of Thomasville Road. At least, as I feathered my way into the traffic, I came away not only well oiled but ready in slightly more than 25 words or less to tackle this hefty point.

What, after all, is "Civilization?" Do we as a profession have anything to do with it? And what about Super-Lube?

Before attempting these weighty matters, I beg you grant me the sentimental point that values do yet exist, and that some are even more worthwhile than others. On the other hand I contrive to grant that ours is, perhaps even plausibly, an age in which the separations defining what is of "value" have become compressed, and that there may even be opinions which would find not a great deal of qualitative difference between getting lubricated in ten minutes or your heart catheterized in fifteen. We are, after all,

a bit suspicious of terming this or that Civilization "Great" since ours is a century in which such "absolute" distinctions have proven themselves all too often relative to something else, and therefore in themselves thoroughly ephemeral and not to be trusted. Traditionally accepted methods of health care, for example, are more skeptically regarded; alternatives sought; and voices are heard even derogatory of the value of vaccination.

As an aside it seems to me that there is something eminently civilized in a society that permits its constituents such latitudes of opinion. But perhaps a "Great Civilization" becomes so by being both more sharply focused and broadly accepting in its essental belief. In his essay written in 1928 and entitled quite simply "Civilization," Clive Bell, the brother-in-law of Virginia Woolf, speculated through 180 pages on what could be demonstrated that was common to those civilizations which have generally been agreed upon as "Great." Never minding his methods of choosing, which surely were in some degree endowed with his own pleasure and prejudice, the models Bell selected for analysis were the societies of Fifth Century Athens and 18th Century France.

Never mind further that the Athenians super-lubed Socrates, and the 18th Century ended with the guillotine first and Rambo a little later; in spite of such flaws, Bell wrote, each of these societies possessed an interacting "Sense of Values and Reason Enthroned." As he further put it ". . . the qualities that distinguish Greek life, thought, and art: the one being Reason, sweetened by a Sense of Values, the other a Sense of Values, hardened and pointed by Reason." The magic of a great civilization, in other words, has something to do with the refinement of a culture's capacity to think, feel, and accordingly act in a manner complimentary to ideals cherished for their qualitative worth. Marvelous though it may be to be lubricated in ten minutes, speed with grease does not a great civilization make; nor for that matter, a quick cardiac catheterization.

In the decision to lubricate there is little of judgement that is subtle or refined; on the other hand cardiac catheterization, routine though it may technically be, does not lack in its recommendation those attributes. The point I am belaboring is one that places our own profession, for all of its consciously and unconsciously perpetrated failings throughout the centuries, squarely within those parameters of thought and action which Bell suggested best test the quality of any civilization: Reason, Feeling, and the conscious ability to appreciate the quality of their interaction.

I do not think I flatter ourselves with my faith that the physician operates within such definitions, that we have throughout the centuries been recognized to do so, and that the general respect accorded the medical profession up to our present time is a public acknowledgment of that truth. Advertising techniques, promotional hoop-la, and a glossy Doctor-Mr.-Businessman image . . . a bit about which Jim Conn wrote in our last issue . . . do not.

And so, I think, we find ourselves at a confusing moment in what is presently the reassessment of our role in a civilized society. Insofar as the medical profession may continue to stand collectively for something beyond mere technical proficiency, we can hardly embrace methods of health care comparable to those of car lubrication or hamburger delivery, with the disease, patients, and physicians computerized to produce a well-oiled flow of patients whose care is slightly underdone. Yet every pressure the private practitioner feels is almost compulsively directed towards that conclusion, and at the expense of our subtle role as arbiters between health and disease.

But take heart: Confusion invariably challenges us to create out of it some order. Even the "least civilized" societies create social structures of varying degrees well improved over chaos and anarchy. If our own moment seems a bit chaotic, I do not doubt that satisfactory answers will be discovered; and I rather like to think that they will in fact be better adapted to social needs than the ones we are discarding; that they will include some of the better defining qualities of civilized Reason and Feeling, and that the role of the Good Physician may even be granted anew the opportunity to be perceived as such by the society.

Our meaning is worthy of our own respect as well as those we will continue to treat.

Charles Moore, M.D.
Tallahassee

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Plain pictures of plain doctoring: Vernacular Expression of New Deal Medicine and Photography

By John D. Stoeckle, M.D., and George Abbott White, (eds.), 250 pages. Price: $25. MIT Press, Cambridge, MA.

This remarkable collection of 80 photographs has been selected from the quarter-million taken during the years 1935-42 by a New Deal agency, Farm Security Administration. They show the Depression-era physician and patient in the clinic, doctor's office and at home during the house call, depict the relationship of patient and physician, and evoke poignant feelings — pathos, anxiety, depression, sorrow or calm.

The accompanying text reminds us that during the Depression era approximately 40% of patient encounters with physicians were during the house call. It reminds us, too, that the ability of the physician to change the course of many disease processes was extremely limited.

Photographer Ben Sahn who took photographs for the FSA observes, "We tried to present the ordinary in an extraordinary manner. But that's a paradox, because the only thing extraordinary about it was that it was so ordinary. Nobody had ever done it before, deliberately. Now it's just called documentary, which I suppose is all right. . . . We just took pictures that cried out to be taken."

The social commentary accompanying the photographs reminds us that Depression times were hard for the physician as well as the patient. Thomas Neville Bonner of Kansas is quoted as saying that not a few doctors were themselves forced onto the relief rolls. It was, he says "the most serious time this generation of doctors has known." Most threatening of all was the desertion of long-time patients for other doctors in the embarrassment of not being able to pay old bills, let alone pay for new services.

On viewing these photographs, this reviewer felt that these were the ordinary folk the likes of which Norman Rockwell captured and idealized in his artistry for the Saturday Evening Post covers.

F. Norman Vickers, M.D.
Pensacola

- Dr. Vickers, an associate editor of *The Journal*, is in the private practice of gastroenterology.

Heart Plan: a complete program for total fitness of heart and mind

By David Copen, M.D., and Mark Rubenstein, M.D., 218 pages. Price: $16.95. McGraw Hill Books, NY, 1987.

Dr. David Copen is Chief of Cardiology of Danbury (Connecticut) Hospital and Associate Professor of Medicine at Yale University, School of Medicine and Dr. Mark Rubenstein is a Board Certified Psychiatrist. These two physicians have

written a book which is called *Heart Plan*, which is aimed at an audience of lay people who are interested in a total fitness program. The book first addresses heart disease as a "heart problem." It discusses the heart in health and disease, describes how the heart works, and some of the simple anatomy and physiology. They then discuss various risk factors including cholesterol, smoking and hypertension, stress and lack of exercise. The authors continue with discussing the experience of having a heart attack, which they call the "ultimate challenge" and adjusting to the new realities after a heart attack.

Part two is a step-by-step strategy for physical and emotional well-being. It starts by setting priorities and realistic goals and then discusses how to avoid invisible emotional entrapment. It also discusses how to modify type A behavior and reduce both large and small stresses. It then develops a program for eating for health and pleasure. Thorough exercise, relaxation, how to stop smoking and overall medical programs are also discussed.

Finally Part three continues with other things a patient and family may need to know including sex life, living with a heart patient, and all about heart surgery as it is considered today and in the future.

This book is extremely well written. The average man or woman should be able to understand it well and it is loaded with practical information regarding many matters about the heart and cardiovascular disease in general. It appears to be scientifically accurate in most respects. The authors strongly emphasized the effects of stress on the individual and heart disease. They talk about stress in general as a most dangerous risk and then further divide stress into something they call the "deadly triple play." The first of these is the Sisyphus Syndrome which is a personality trait whereby individuals joylessly and ceaselessly strive for difficult and unattainable goals both in the work in their personal lives much like the legendary King of Corinth who was condemned to Hades and given the endless task of rolling a huge stone up a mountain after which it would roll to the foot of a mountain and the laborers would begin anew. The book then goes on to discuss Type A behavior and also a condition called "emotional entrapment," which involves a frustrating and demoralizing situation or relationship in which there is no easy or acceptable way out apparently.

While it strongly emphasizes the psychological and emotional aspects of cardiovascular disease and stress and how these affect the risk, it does not go overboard stating that these are the only important factors, but rather these play a significant role in combination with all of the other significant risk factors including hypertension, lack of exercise, obesity, smoking and the various lipid abnormalities.

The book offers a complete program for total fitness of the body, heart, and mind. I believe that it does it admirably well without overemphasizing any particular aspect and is a book any well educated patient or physician who has had heart disease or whose spouse has had heart disease will find very helpful and encouraging.

Mark V. Barrow, M.D.
Gainesville, FL

- Dr. Barrow is in the private practice of internal medicine.

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Hernando County Auxiliary supports sheriff's Junior Deputy League

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

The Hernando County Medical Auxiliary is actively supporting the Sheriff's Junior Deputy program which just got underway this year. This community need is being fulfilled as one of the goals of the Auxiliary in providing community service. Funds raised by Auxilians help provide manuals, badges for children and adults, cards, and films.

Geared to fifth graders the objectives of the Junior Deputy League are to produce educational programs which aid in building respect for law enforcement. Monthly presentations are given on various topics to fifth grade classes by members of the sheriff's office. Planned for the end of the school year are graduation ceremonies with the Sheriff awarding certificates of accomplishment to all fifth grade students completing the program. Students are also required to complete an essay on any of the topics covered during the sessions.

The program is organized as a non-profit corporation with the Sheriff as the Chief Executive. Interested citizens compose the membership. Financial support is provided by donations from businesses and organizations. A certificate was awarded to the Hernando County Auxiliary for its support and donations in helping to implement the Junior Deputy League in Hernando County.

Scheduled programs for presentation during the year included:

1. **History of Law Enforcement:** each student received a Junior Deputy League Manual, members of the Sheriff's office were introduced, and a film was shown, "A Special Kind of Guy."
2. **Display and Explanation of all Equipment Carried on the Deputy's Person and Vehicle:** students were able to participate with a question and answer period following the presentation.
3. **Shoplifting is a Crime:** copy of statute on retail theft distributed to students, explanation of statute with repercussions both to person charged and to society, and showing a film on shoplifting.
4. **Drug Abuse:** explanation of laws, drug identification, use of a display of drugs, consequences of taking drugs and alcohol with a film on drug and alcohol abuse.
5. **Bicycle Safety, Safety and Behavior on the School Bus, and Latchkey Kids:** all of these topics to be discussed as reflective of the needs and concerns of the students and the community.

An evaluation of the program shows increased awareness among the students with results of a safer and healthier community.

The Junior Deputy League was organized with the help of the Hernando County Medical Auxiliary President, Mrs. Clemente Nunag (Beatriz) and is being continued for the following year with the new Auxiliary President, Mrs. Richard Berrios (Zaida). Auxilians support this program as an effective tool in the fight to prevent crime and promote health in their own communities.

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Meetings

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MAY

Chest Pain 1987, May 1-2, New World Landing, Pensacola. Contact: (904) 434-1093.

Gulf Coast Cardiology Seminar — 1987 "Chest Pain", May 1-2, New World Landing, Pensacola. Contact: William S. Pickens, M.D., (904) 434-1093.

Annual CME Seminar for the Practicing Physician, May 2, Sheraton Sand Key, Clearwater Beach. Contact: M.P.R. Nathan, M.D., (904) 596-1822.

Radiology Review Course, May 3-8, Sheraton Bal Harbour, Miami. Contact: Lucy R. Kelley, (305) 674-2681.

Comprehensive Review and Update in Emergency Medicine, May 4-8, Hyatt Regency Westshore, Tampa. Contact: Eilleen Weimerskirch, M.D., (214) 550-0911.

Series on Diagnostic Parasitology: The Microscopic Diagnosis of Intestinal Parasites, May 7-9, DEVETEC, Inc., Sarasota. Contact: Donald L. Price, Ph.D., (813) 351-1454.

Issues in Colon and Rectal Cancer — '87, New World Landing, Pensacola. Contact: Allan Patton, M.D., (904) 434-4785.

ACLS Instructors Course, May 8-10, St. Augustine Technical Center, St. Augustine. Contact: Mrs. Margo Kinsey, St. Augustine Technical Center, St. Augustine 32084, (904) 824-4401.

Five-day Management of Diabetes Mellitua, May 11-15, USF College of Medicine, Tampa. Contact: Anthony Morrison, M.D., (813) 974-4360.

Pediatrica for the Practitoner — Update on Learning Diaabilities, May 15, Bay Harbor Inn, Tampa. Contact: Herbert Pomerance, M.D., 813-974-4214.

Review Course for Certification in Internal Medicine, May 17-22, Key Biscayne Hotel, Key Biscayne. Contact: University of Miami, Dept. of CME, (305) 547-6716.

Magnetic Resonance Imaging, May 18-22, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Mock Trial, May 23, West Florida Regional Medical Center, Pensacola. Contact: Margie Rickell, (904) 478-4460.

Changing Trends in Emergency Care, May 23, Holy Cross Hospital, Ft. Lauderdale. Contact: Ellen Lavoie, (305) 771-7423.

Practical Applications in Internal and Emergency Medicine, May 25-29, Marco Island Resort, Marco Island. Contact: Albert J. Finestone, M.D., (215) 221-4787.

Master Approach to Cardiovascular Problems, May 30-June 1, Contemporary Hotel, Lake Buena Vista. Contact: Agustin Castellanos, M.D., (305) 549-7124.

JUNE

Family Practice '87, June 8-11, Hilton Hotel, Orlando. Contact: Thomas Stewart, M.D., (912) 452-2213.

Workshop: Excercise Stress Testing in Ambulatory Cardiac Monitoring, June 12, Stouffer Orlando Resort, Orlando. Contact: Donald B. Twiggs, M.D., (904) 398-5667.

Contemporary Issues in Medicine, June 12-14, Amelia Island Plantation, Amelia Island. Contact: Jeanette Stone, 1-800-423-4992.

Diagnosis and Management of Reapiratory Disease, June 19-21, Dutch American Hotel, Orlando. Contact: Deborah Wilderson, (303) 798-9682.

Twelfth Annual Florida Suncoast Pediatric Conference, June 21-24, Trade Winds Resort, St. Petersburg. Contact: Paul B. Welty, M.D., (813) 323-1804.

Two-Dimensional Echocardiography, June 22-26, Orlando. Contact: American College of Cardiology, 1-800-253-4636.

Ninth Annual Cuban Medical Association Congress, June 28-July 5, Sheraton Bal Harbour, Bal Harbour. Contact: M. Viamonte Jr., M.D., (305) 674-2680.

JULY

1987 Clinical Conference on Pre-Hospital Emergency Care, July 9-12, Orlando Hyatt, Kissimmee. Contact: Registrar, (305) 628-4800.

AUGUST

Fourteenth Annual Review Course for Certification in Internal Medicine, "Fundamental and Clinical Aspects of Internal Medicine," August 2-15, Key Biscayne Hotel and Villas, Key Biscayne. Contact: Jose S. Bocles, M.D., (305) 547-6063.

Coronary Heart Disease: Current Concepts, August 14-15, Orlando Hyatt Hotel, Orlando. Contact: Karen DeBent 1-800-421-3756.

SEPTEMBER

Magnetic Resonance Imaging: A Technologist's New World, September 10-12, Peabody Hotel, Orlando. Contact: Martin Silbigu, M.D., (813) 974-2538.

Current Concepts in the Diagnosis and Management of Adult Heart Disease, September 18-19, New World Landing, Pensacola. Contact: (904) 478-4460.

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Physicians Wanted

THREE PHYSICIANS NEEDED! GENERAL SURGEON, OB/GYN, UROLOGIST. Excellent practice opportunity in scenic western, North Carolina. Snow skiing, trout fishing, etc. High income potential and low malpractice rates. Call: David Spangler, Administrator, Blue Ridge Hospital System, (704) 765-4201.

INTERNIST WANTED to join two man practice in Winter Park, FL. Woman applicants welcomed. Call (305) 645-3556.

OB/GYN, BC/BE, for association leading to early partnership and eventually to take over. Spanish speaking will be preferred. Contact: Nesim Halfon, M.D., 723 58th St., Kenosha, WI 53140-4136. Phone: Office (414) 658-1344; Home (414) 694-4060.

FULL- AND PART-TIME ER POSITIONS available in numerous Florida locations. Directorship opportunities also available. Competitive remuneration, including comprehensive liability coverage. For details contact Lynn at NES: (800) 645-4848.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

FAMILY PRACTICE/INTERNAL MEDICINE, BC/BE wanted for rapidly expanding practice. Excellent patient base and unlimited potential to join young internist and GP on FL's east coast. Excellent salary and benefits. Box C-1364, P.O. Box 2411, Jacksonville, FL 32203.

WANTED: SPECIALISTS in all surgical and medical fields for evaluations of medical records. Excellent compensation. Send your C.V. to Miss Eva Wagda, 1040 N.W. 6th St., Boca Raton, 33432 or phone 1-305-394-3311.

DO YOU WANT TO SHARE a thriving dermatology practice? Do you enjoy year around outdoor recreation? You should contact us . . . a progressive multi-specialty group of 68 physicians in a pleasant, growing community. We offer a liberal financial package and outstanding benefits. Send curriculum vitae and references to: Michael T. Anderson, M.D., Willmar Medical Center, 101 Willmar Avenue, Willmar, MN 56201.

FAMILY PHYSICIAN: family practice physician, BC/BE, to join a progressive growing multi-specialty group. Salary and benefits are excellent and environment is beautiful. Please respons with CV to Dr. Joseph A. Hill, Doctors Clinic, 2300 Fifth Avenue, Vero Beach, FL 32960.

FAMILY PRACTICE OPPORTUNITY: Share in a rapidly expanding practice on the Gulf Coast Sarasota/Bradenton. X-ray and laboratory on-site. Adjacent to HCA Hospital. Built in referrals. Share call nights, weekends, and holidays with physicians. Reply P.O. Box 14744, Bradenton, FL 34280.

PRACTICE FAMILY MEDICINE with the people in rural Iowa communities where the quality of life is superb. Solo and group practice opportunities available including guaranteed salaries and full benefit packages. For an immediate response please call 1-800-532-1411, Ext. 8204 (Iowa), or 1-800-247-3121, Ext. 8204 (USA).

FAMILY PRACTICE — Opportunity to join 3 board certified F.P.'s in a rapidly growing practice at the beach. Excellent community to live and grow next to a large metro area. Practice is strong in wellness preventive and psychosocial medicine. Salary negotiable with opportunity to buy in. Contact North Beaches Family Practice, 100 Royal Palm Drive, Atlantic Beach, FL 32233, 904-241-5107.

FAMILY PRACTICE — Altamonte Springs — north of Orlando. Career opportunity, BC/BE — office, hospital practice, in new office. Attractive financial package. Send C.V.to Troy Overstreet, M.D., 120 Sunnytown Road, Cassleberry, FL 32707, 305-339-7171.

DIRECTOR, PHYSICAL MEDICINE AND REHABILITATION: Direct/develop rehabilitation program for new 24-bed inpatient unit at 825-bed hospital in southwest Florida coastal community with comfortable lifestyle, cultural amenities, good schools, university/college. BE/BC physicina with 2+ years clinical/administrative experience. Hospital based/excellent salary/malpractice/relocation/dues/CMC/office space/Holidays/vacation/insurances. Contact Mary, Tyler and Co., 9040 Roswell Rd., Atlanta, GA 30338. Collect 404-641-6411.

VETERANS ADMINISTRATION Outpatient Clinic in West Palm Beach Florida recruiting for a part-time dermatologist. Hours are negotiable. VA is an affirmative action employer. Write or call Seymour Chasan, M.D., Chief Medical Officer, VA Outpatient clinic, 301 Broadway, Riviera Beach, FL 33404 (305)854-2800, X200.

FLORIDA FAMILY PRACTITIONER needed for rural town in northwest Florida. Rural area with access to beautiful white beaches of the Gulf of Mexico, hunting, fresh and salt water fishing, for a leisure and comfortable life-style. Established primary care practice in a modern and well equipped facility. BC/BE preferred but not required. Salaried position with fringe benefits to include paid malpractice. Reply with CV to H. Armstrong, Admin., P.O. Box 40, Wewahitchka, FL 32465; (904) 639-5986.

OBSTETRICIAN/GYNECOLOGIST — Board eligible of Board certified OB/GYN physician to be associated with progressive hospital that has a newly-remodeled, state-of-the-art OB/GYN Department. Located in a Midwestern metropolitan area of 110,000 population. Excellent opportunity for individual or group practice. Superb educational, cultural and recreational activities. For more information call: Larry W. Pugh, President, Allen Memorial Hospital, 1825 Logan Ave., Waterloo, Iowa 50703, Phone: (319) 235-3987.

GENERAL INTERNISTS, FAMILY PRACTICE, GERONTOLOGIST, EMERGENCY CARE MEDICINE — 40 physician multi-specialty Group in West Palm Beach, Florida seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 2 years. Send CV to: Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 N. Olive Ave., West Palm Beach, FL 33401.

THE FLORIDA MENTAL HEALTH INSTITUTE, UNIVERSITY OF SOUTH FLORIDA, announces a full-time faculty appointment for an internist/geriatrician within the Department of Aging and Mental Health. Responsibilities include working with an established multidisciplinary geriatric mental health program in delivery of clinical services in residential and outpatient settings as well as participation in education and research programs. Experience and special training in geriatrics preferred. Beginning date of appointment is August, 1987. Submit resume and letter of interest indicating salary requirements no later than May 29 to: Dr. Larry W. Dupree, Chairperson, Department of Aging and Mental Health, Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, FL 33612. NOTE: According to Florida Law, applications and meetings regarding the same are open to the public. USF is an Equal Opportunity Employer.

INTERNAL MEDICINE — BC/BE to join a 33 physician multispecialty clinic. Guaranteed salary plus benefits first two years. Please submit CV to: Administrator, Suncoast Medical Clinic, Inc., 700 6th Street South, St. Petersburg, FL 33701.

MEDICAL GENETICIST: Private setting for prenatal diagnosis, clinical genetics, counseling and hospital consultation. Requires M.D., Florida medical license, BE/BC in medical genetics with one to 2 years' training in pediatrics and two years' clinical genetics Post-doctoral training. Forty hours; 9-5 p.m. salary; $40,000 annually. Resume only to Job Service of Florida, 1350 N.W. 12th Ave., Room # 280, Miami, FL 33136. Ref.: Job Order # F1-4539646.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

PSYCHIATRIST — full-time position open for Board Certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient and limited inpatient on-call. Florida license needed. Reply to Box C-1349, P. O. Box 2411, Jacksonville, FL 32203.

INTERNIST WANTED. Board certified to join busy four-man Internal Medicine/Cardiology practice in North Miami, FL. Office and hospital based. Mial resume to: Richard Fien, M.D., 12900 NE 17th Ave., N. Miami, FL 33181. (305) 891-5460.

STUDENT HEALTH PHYSICIAN — SURGERY — to join our team of physicians and other providers in the delivery of primary ambulatory health care to 22,000 students of the Florida State University. Vacancies may be available by Spring/Summer 1987. Emphasis on sports medicine. Other duties may include office gynecology, minor surgery, orthopedics, general medicine. BE/BC in family practice, adolescent medicine or sports medicine preferred. There is no medical school affiliation. Interested candidates must be currently licensed in Florida. Prior experience in sports medicine necessary. Salary competitive. Send CV to L.F. Gagliano, M.D., Clinical Director, Student Health Services, Florida State University, Tallahassee, FL 32306-2014.

STUDENT HEALTH PHYSICIAN — FAMILY PRACTICE — to join our team of physicians and other providers in the delivery of primary ambulatory health care to 22,000 students of the Florida State University. Vaccancies may be available by Spring or Summer 1987. Duties include office type gynecology, minor surgery, orthopaedics, general medicine. BE/BC in Family Practice, adolescent medicine and/or sports medicine preferred. Internists and pediatricians also considered. There is no medical school affiliation. Interested candidates must be currently licensed in Florida. Competitive salary and benefits. Send CV to L.G. Gagliano, M.D., Clinical Director, Student Health Services, Florida State University, Tallahassee, FL 32303-2014.

TIRED OF HMOs? Conduct your specialty or primary care practice in a traditional setting in a growing community south of Ocala. Demand for all specialties exceeds supply (AMA market profile available). The new Mockingbird Hill Professional Center is now open with lease/purchase option. Opportunity now exists for custom interior design. Lab and x-ray on-site and private ambulatory care center provides a referral base. Only 10 minute drive to HCA hospital. For information call or write Carol Roberts, Care-1, Inc., 1805 S.E. Lake Weir Ave., Ocala, FL 32671 or 904-351-0789

BOARD CERTIFIED GENERAL SURGEON, as associate, private practice in Orlando. Send CV, references, photo to Box C-1366, P.O. Box 2411, Jacksonville, FL 32203.

MOLECULAR BIOLOGIST — The Department of Pathology, College of Medicine, University of Florida is seeking a molecular biologist (Ph.D. or M.D.) to fill a tenure-track position at the Assistant Professor leve. Research experience in human molecular genetics, especially involving the HLA complex is highly desirable. The successful candidate will be expected to develop an independent research program in human molecular genetics, participate in the education and training of graduate students and provide technical expertise for the development of a Clinical Pathology Laboratory of Molecular Biology. Starting date for the position is 7/1/87. Applicants should submit their curriculum vitae, plus copies of three publications which best exemplify their work, and the names of three references to Edward K. Wakeland, Ph.D., Associate Professor, Box J-275, College of Medicine, University of Florida, Gainesville, FL 32610. Recruiting deadline is 4/30/87. Equal Opportunity Employment/Affirmative Action Employer.

PSYCHIATRIST: Full-time position open for Board Certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient and limited inpatient oncall. Florida license needed. Reply to George A. Michas, M.D., Psychiatrist, 235 Carmel Drive, Ft. Walton Beach, Floirda 32548.

TALLAHASSEE, FL — Position available for Board Certified Family Practitioner or Emergency Physician at ambulatory care center owned and operated by local physicians. Opportunity available to begin private practice with minimal start-up costs if desired. Exceptional Florida community. Physician group is small, progressive, consumer oriented, offering unique opportunity for the right M.D. Please contact Douglas Sherman, M.D., or Bill Riddle at Physician Care, (904) 386-2266.

PEDIATRIC SURGEON, PLASTIC AND RECONSTRUCTIVE SURGEON, OBSTETRICS AND GYNECOLOGY. 40 physician multispecialty group in West Palm Beach, FL seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Finanicial package based on incentive with full partnership in two years. Send CV to: Joseph D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 N. Olive Ave., West Palm Beach, FL 33401.

INTERNIST WANTED: For association with four internists, southeast coast of Florida. Board qualified, salary: $50,000 plus percentage. Early partnership assured. Reply to P.O. Box 768, Lake Worth, FL 33460.

CARDIOLOGIST: Excellent opportunity to join a well-established three physician cardiology group. Board Certifies/Board Eligible non-invasive physician sought to practice the lates in doppler echo cardiography, pacemaker and swanganz insertions along with nuclear cardiology. Practice is expanding due to strong community and hospital support. Must be able to acquire Florida license. Excellent base salary with profit sharing incentives. 20 miles to the beautiful western coastline, on the Gulf of Mexico, easy access to Tampa and Orlando. For more information on this and other openings, send CV or call Durham Medical Search, Inc., 6300 Transit Rd., P.O. Box 478, Depew, NY 14043. In NY call: (800) 367-2356, national (800) 633-7724.

OB/GYN, ORTHOPEDIC SURGEON: Coard certified or eligible to join 15 member group in progressive northwestern Wisconsin community. Modern, well-equipped hospital located adjacent to our facility. Close to Minneapolis, Eau Claire, and Duluth, the Rice Lake area offers excellent educational, religious and community activities in addition to exceptional sports, hunting, fishing, and recreational opportunities. For more detailed information regarding our group, please contact Mark T. Nymo, M.D., Indianhead Medical Group, 1020 Lakeshore Dr., Rice Lake, WI 54868. (715) 234-9031.

EXCELLENT PHYSICIAN OPPORTUNITIES NATIONWIDE. All specialties, however, FPs, IMs, OBGs, ORSs and PDs are especially needed. Finanical guarantees and benefit packages available in various practice types and community sizes. We'll help you locate the right position. For confidential interview call (713) 681-7454. The Hilton Group, P.O. Box 920970-E24, Houston, TX 77018.

Situations Wanted

FAMILY PRACTICE PHYSICIAN — FLORIDA LICENSURE Board Certified seeks 40 hour work week in Clinics, Public Health, Locum Tenens. Call or write: Celedonio C. Barrameda, M.D., 312 NE Ardsley Dr., Port St. Lucie, FL 33452. Phone: (305) 878-6608.

HOUSE PHYSICIAN seeks position in Florida, has Florida license, four years American hospital experience. Please write c/o: Dr. Bala, 1815 Christian Dr. #408, Toledo, OH 43613. Phone: (416) 474-3430.

GENERAL SURGEON, Board certified, FACS, Florida licensed. Seeks relocation. Will consider any opportunity. Box C-1387, P.O. Box 2411, Jacksonville, FL 32203.

UNIVERSITY TRAINED PEDIATRICIAN with flexible interest and background in general medicine and emergency medicine wants to relocate to Florida. Available April 1987. Contact: Dr. Vaswani, 6535 Premier Dr., Apt. G-8, Nashville, TN 37209.

FAMILY PRACTICE PHYSICIAN, Florida licensed, with 15 years experience in primary care seeks office based position in Palm Beaches. C-1376, P.O. Box 2411, Jacksonville, FL 32203.

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GENERAL SURGEON, Board certified, FACS, Florida licensed. Seeks relocation. Will consider any opportunity. Box C-1387, P.O. Box 2411, Jacksonville, FL 32203.

GENERAL INTERNIST, Board Certified, FL license, looking for private practice opportunity (solo, partnership, group) in Florida. Wiling to buy established practice. Available July 1987. C-1382, P.O. Box 2411, Jacksonvile, FL 32203.

FAMILY PRACTICE PHYSICIAN, Florida licensure, Board Certified seeks 40 hour work week in Clinics, Public Health, Locum Tenens. Call or write to: Celedonio C. Barrameda, M.D., 312 N.E. Ardsley Dr., Port St. Lucie, FL 33452. Phone: (305) 878-6608.

UROLOGIST: BE, Florida licensed, presently chief resident university program. Seeks practice opportunity. Available 7/87. Please call: (201) 667-7863 or write: N. Terzian, M.D., 221 Harrison St., B-4, Nutley, NJ 07110.

BOARD CERTIFIED OB/GYN, 46, seeking position in Dade or Broward county. Prefer group practice, hosptial based position acceptable. Box C-1390, P.O. Box 2411, Jacksonville, FL 32203.

HOUSE PHYSICIAN seeks position in Florida, has Florida license, four years' American hospital experience. Please write: Dr. Bala, 1815 Christian Dr., #408, Toledo, OH 43613. (419) 474-3430.

GENERAL SURGEON, Board certified, FACS, Florida licensed. Seeks relocation. Will consider any opportunity. Box C-1387, P.O. Box 2411, Jacksonville, FL 32203.

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FAMILY PRACTICE N.E. FT. LAUDERDALE. Established 20 years. Very active. High grade demographic patient profile. Up to date, well maintained office and equipment, including x-ray. Ideal for FP or internist. Realistic terms. Retiring physician. Box C-1383, P.O. Box 2411, Jacksonville, FL 32203.

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ESTABLISHED GYNECOLOGICAL PRACTICE — in rapidly developing suburb of Tampa, FL. Practice has over 4,000 patients, excellent reuptation. Priced for high return on buyers investment. Terms negotiable. Call (813) 985-5253 or write WomenCare, 1140½ N. 56th St., Tampa, FL 33617.

RETIRING BOARD CERTIFIED OB/GYN selling or leasing completely equipped office. Capacity for 2 or more Ob-Gyns. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone 305-667-3677.

LIFE STYLE CHANGE? Island practice, Fla. west coast. Office only, internal medicine. Four days summer, five days season. Gross $125,000. Cost $50,000 including equipped office available Summer/Fall '87. C-1375, P.O. Box 2411, Jacksonville, FL 32203.

PEDIATRICS: Well-established Gainesville practice. Pediatrician will retire or semi-retire and will assist in transition. Fully equipped office available for rent or sale, full financing available. C-1373, P.O. Box 2411, Jacksonville, FL 32204.

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TAMPA, FLORIDA: General surgery; solo practice. Active, growing 20$ year general and gynecological surgical practice for sale. Located near three major hospitals; 2,700 sq. ft. office space for rent; lease or buy equipment. Will stay to introduce, if desired. Annual practice gross: $300,000. Write Box C-1386, P.O. Box 2411, Jacksonville, FL 32203.

CORAL GABLES. General medical practice and office for sale. Grossing over $100,000. Unlimited potential. Terms negotiable. Box C-1380, P.O. Box 2411, Jacksonville, FL 32203.

FLORIDA WEST COAST: Well-established ophthamology practice for sale. Grossing $300,000. Practice can be expanded. Equipment included. Will introduce. Financing can be arranged. Cox C-1381, P.O. Box 2411, Jacksonville, FL 32203.

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Real Estate

SALE/LEASE: Medical Imaging facility, Ft. Lauderdale. Building and Equipment. Turn Key. Siemens-Kodak-Technicare, plus additional equipment space. Herman E. Rolfs, M.D. (904) 863-8110.

FOR LEASE: Office space available in multi-specialty medical complex. From 943 sq. ft. to 1600 sq. ft. Central location close to hospitals. Rapidly growing area, in Brevard County. C-1367, P.O. Box 2411, Jacksonville, FL 32203.

COLORADO MOUNTAIN REAL ESTATE: Large selection properties from small ranches to riverfront lots. Aspen area. Adjacent wilderness area. Very realistic prices. Thomas Beach, M.D., (904) 387-7300.

MEDICAL OFFICE CONDO FOR SALE OR RENT: Approx. 1600 sq. ft. furnished excellent professional building and location. North Miami Beach, FL. Available June 1, 1987. Call 305-944-1431.

MEDICAL OFFICE space available for immediate occupancy. 2,235 sq. ft. at $12.50 per sq. ft. Ideal location; within walking distance of St. Joseph's Hospital. 4612 N. Habana. Contact: Gretchen at (813) 877-7434, Tampa, FL 33614.

REAL ESTATE FOR SALE: Medical office building, five offices, 6,600 sq. ft. near two hospitals, small down payment. Owner will carry mortgage fully occupied. Call (904) 788-8687 evenings or write to: I Leider, M.D., 568 Pelican Bay Dr., Daytona Beach, FL 32019.

BRADENTON: Medical office building, 2,650 sq. ft. with reception, examination rooms, x-ray, laboratories and offices. Excellent location with ample parking. $250,000. Call Walter P. Schoerr (813) 795-2525. Neal & Neal Realtors.

OFFICE SPACE TO SHARE with one or two physicians. 3,500 sq. ft. Full laboratory. X-ray machine. Excellent North Palm Beach location. Terms negotiable (305) 844-2553.

DUE TO RETIREMENT, LEASE/SALE general surgeon's office located 2300 E. Concord St., Orlando, FL 32803, with or without equipment and furniture. Jorge E. Ravelo (305) 275-6858.

RADIOLOGY OFFICE FOR LEASE, SALE OR JOINT VENTURE: Rapidly growing area, SE Florida Coast Hospital and three medical building complex: 30 physicians. Box C-1384, P.O. Box 2411, Jacksonville, FL 32203.

MEDICAL CONDO FOR SALE. Approximately 1,500 sq. ft. Completely furnished. Ready to move in. Price: $280,000. Contact: Arnold D. Berliner, M.D., 1050 N.W. 15th St., Suite 103A, Boca Raton, FL 33432.

PRIME MEDICAL OFFICE SPACE AVAILABLE directly across from Bethesda Hospital in Boynton Beach (Palm Beach Co.) 4,800 sq. ft. total, will subdivide as required; Asking $9 per sq. ft., will include leadhold imp. if all space taken; simple lease with no add-ons; please call (305) 737-8776 and leave message.

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PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

WE BUY, SELL, LEASE SERVICE new and preowned medical instrumentation: Holter-Stress-Ultrasound-EKG Lab etc. Contact New Life Systems, Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065; 305-972-4600.

MEDICAL PRACTICE SALES AND APPRAISALS. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our Brokerage Division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004, (215) 667-8630.

FREE APPRAISAL KIT, Nation's largest practice Broker $25,000,000.00 in 1986. Call or write for present listings or Free Kit. RH$ Medical Group, 12651 Briar Forest -180, Houston, TX 77077. (713) 496-7777.

Equipment

HOLTER MONITOR: Quality scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretation, scan price $35.00. Recorders loaned, leased or purchase new dual-channel holter recorder, $750.00 with two year warranty. For more information call collect, Advance Medical & Research Center, Inc., 1-313-373-1199.

SALE/LEASE Medical Imaging Facility, Fort Lauderdale — Building and Equipment. Turn Keyl. Siemens-Kodak-Technicare plus additional equipment space. Herman E. Rolfs, M.D. (904) 863-8110.

FACUDA SPIRO SCAN (2 avaiable)(pulmonary func.) $2,000; Facuda Denski Cardiac ECG, FCP-11 (2 available) $4,000; Titmus Vision Tester $800; Audioscope Demo Kit (hearing test) $300; Glucometer 2 (Blood Glucose test) $90. Call (305) 667-2800.

Meetings

BIOFEEDBACK THERAPIST TRAINING WORKSHOP — Four day program to train health professionals to provide effective biofeedback therapy. Many jobs available. Training site luxury beachfront hotel. Medical CEUs pending. Tentative 1987 dates: June 11-14. One day compuerized biofeedback workshop on May 16. For brochure contact: Hartje Stress Clinic, 2429 University Blvd. West, Jacksonville, FL 32217. (904) 737-5821.

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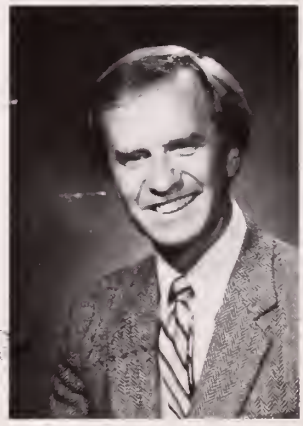
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*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period, the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours, then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol, and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Light-headedness; mental depression manifested by insomnia; lassitude; weakness; fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place; short-term memory loss; emotional lability; slightly clouded sensorium; and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy and vivid dreams appear dose related.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS — *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE — *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

1. INDERAL LA National Compliance Evaluation Program. Data on file. Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.

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For more information call or write:

Admissions Coordinator
Fair Oaks Hospital at Boca/Delray
5440 Linton Boulevard — 305/495-3737
Delray Beach, FL 33445 — 305/495-1000

FAIR OAKS HOSPITAL
AT BOCA/DELRAY

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

MAY 1987, Vol. 74, No. 5

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This month's cover of *The Journal* features a billboard displaying the campaign for public involvement in the liability crisis. The Special Article by Donald C. Jones elaborates on this subject.

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Organized medicine and the need for support



Now that the legislative session is well underway, the perception of even the most casual observer is that there are serious problems in the Sunshine State. Many of these are detailed in the Zwick State Comprehensive Plan Committee Report and the feedback from the speaker's advisory committee reports. Florida's infrastructure, water, air, education, facilities, resources, people, roads, indigent and under-insured medical care, all burgeoning, "all in balance" and all "behind the times." These programs need a massive transfusion of dollars and "sense" in order to make us a quality state. We need both the acceptance and the quality to keep good businesses coming. We need to have jobs for our new residents, to have the amenities that make people want to live in Florida, not just to retire and sleep away in a torpid and indolent lifestyle. Encouragement of high-tech industry and the producers, in this age of information, to desire us as a place to work, play and exercise our minds, is both necessary and desirable.

The legislature is filled with words and with debate about numerous philosophies and ideas. There are multitudinous lobbies all with special axes to grind and all with positive as well as protectionist programs that maintain a "status quo." Much of the legislative thrust this year deals with taxes and budgets, a perennial problem that has mushroomed into a crisis. Many deal with law and regulation, a few are genuine new ideas, and most deal with contemporary problems alluded to by newspapers, editorials and political rhetoric.

In the last 15 years, medicine in Florida has been preoccupied to the point of paranoid-schizophrenia about liability and the implications of it on the collective and individual psyche of its members. This has, as fallout, many emotional and financial implications that virtually every inhabitant of this state and the entire country is well aware. The legislature has made efforts to commensurate with its willingness and ability to address this issue. As even the most casual observer can attest, nothing substantive has been accomplished. Much could work in time but that commodity is precious and most physicians and business entities do not have the luxury of indulging themselves in the passivity of patience "until the law works."

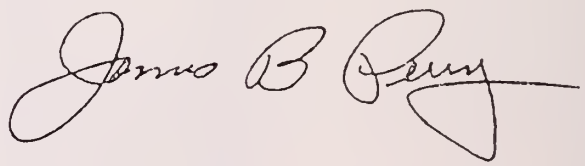
We have seen anguish because of this. The problems are caused by unconscionable liability premiums and cost of tail coverage which continues to skyrocket. Quotes of one half million dollars for one million dollar coverage are promulgated as a probability by the early 1990s. The concern and heartburn frequently expressed by individuals, groups, and the entire county societies as well as our parent organization, the American Medical Association, are not unusual. In one county we have seen virtually every physician forming "his own" medical association. Numerous small groups often ventilate righteous indignation, lashing out at whatever organization or person that seems appropriate and perhaps feeling better for it. There are new organizations almost as numerous as federal programs, all with acronyms at times as numerous and lengthy as those designated by government. Some of these raise significant dollars, hire lobbyists, attorneys, take out newspaper ads, and even testify at hearings and before the legislature in committee. They occasionally have an impact on some individuals and often are used by

attorneys or politicians, quoting their statements, for an appearance of divisiveness that destroys the credibility of the group as a viable entity. Often the adversaries of the group use statements partially or entirely taken out of context that then render the organization they represent totally impotent. Well-meaning, frustrated physicians often contribute untold time, finances, and effort, only to become more frustrated and negative than they were prior to their militant activity.

Perhaps I have become pessimistic and cynical, but I suppose 12 years in Tallahassee and witnessing numerous sessions have caused this distress. We know that once elected, an individual can become aloof and unresponsive. This is expected. The legislature must react one way or another to between one and 3,000 bills and cannot understand more than a few of them. The subcommittee structure is such that if a few people understand, often with vested interest, the rest follow. The pros and cons of an issue are rarely objectively debated in depth. Votes are often predetermined by perceptions of a chairman who has been briefed by a trusted lobbyist with whom he may have been acquainted for a long period of time and in whom he may have complete confidence; in some cases clouding or obscuring an issue.

It is important that a grass-roots effort for whatever reason impact upon and help in a positive and friendly way, established procedures that build on previous strengths and credibility that have been built up over decades. The adversaries of medicine have been more firmly entrenched and though few in number have in the past controlled key positions in the governmental process. It really only takes about six people to do this. Physicians, though they seem to be very positive and active in the process, must deal with the established rules and order as it exists. To this end it seems that the individual doctor, as he desires to better his lot and that of those who will inherit his profession and the fruits of his efforts, should be one with his fraternity and brotherhood. He cannot be an island unto himself. Organized medicine needs his enthusiasm, his emotional and financial support. Placing this energy and commitment of dollars in other areas is a waste and only leads to more anxiety and frustration.

This is a plea for sanity, reason and unity. We all need and desire to have every physician commit to the organization and its proven programs of effectiveness. We continue to need everyone's help and support. We may not succeed every time with all of our desires, but with unification and one voice, we shall not fail in the eventual solution to the most vexing, soul-searching problem of our times.



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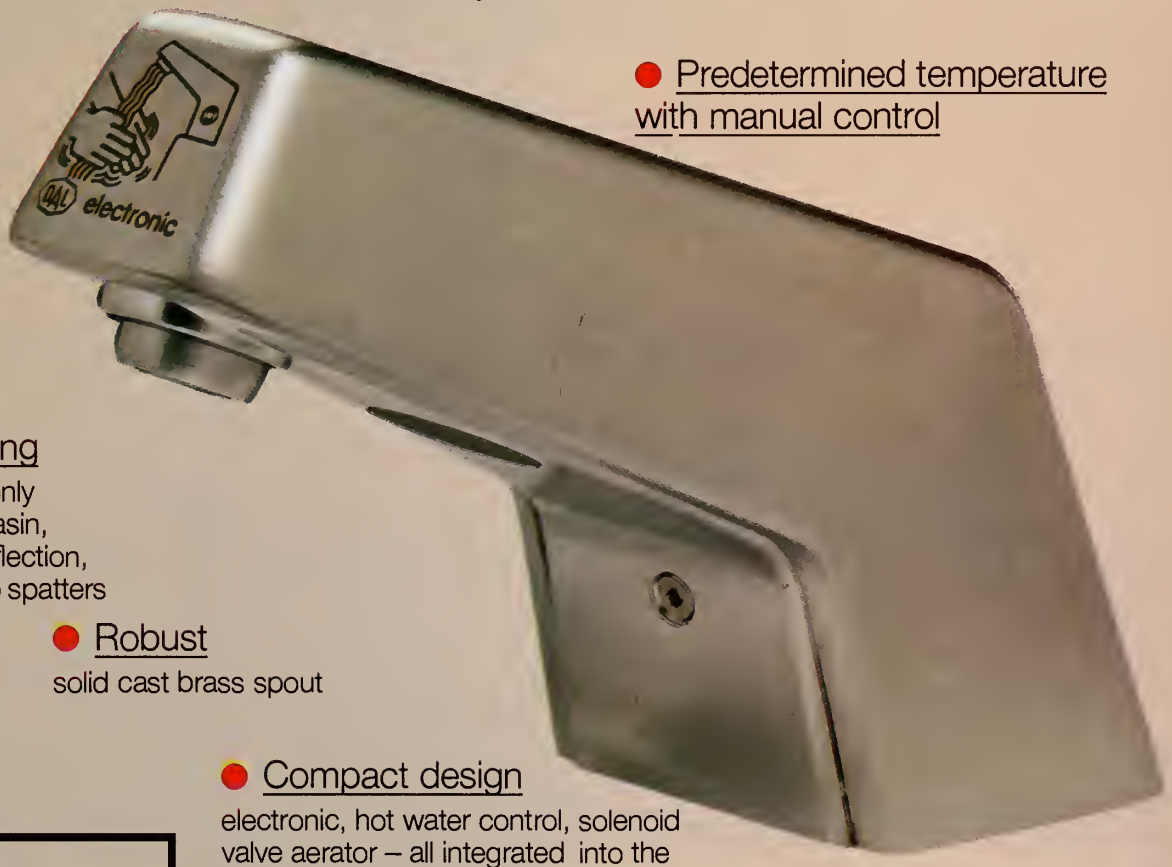
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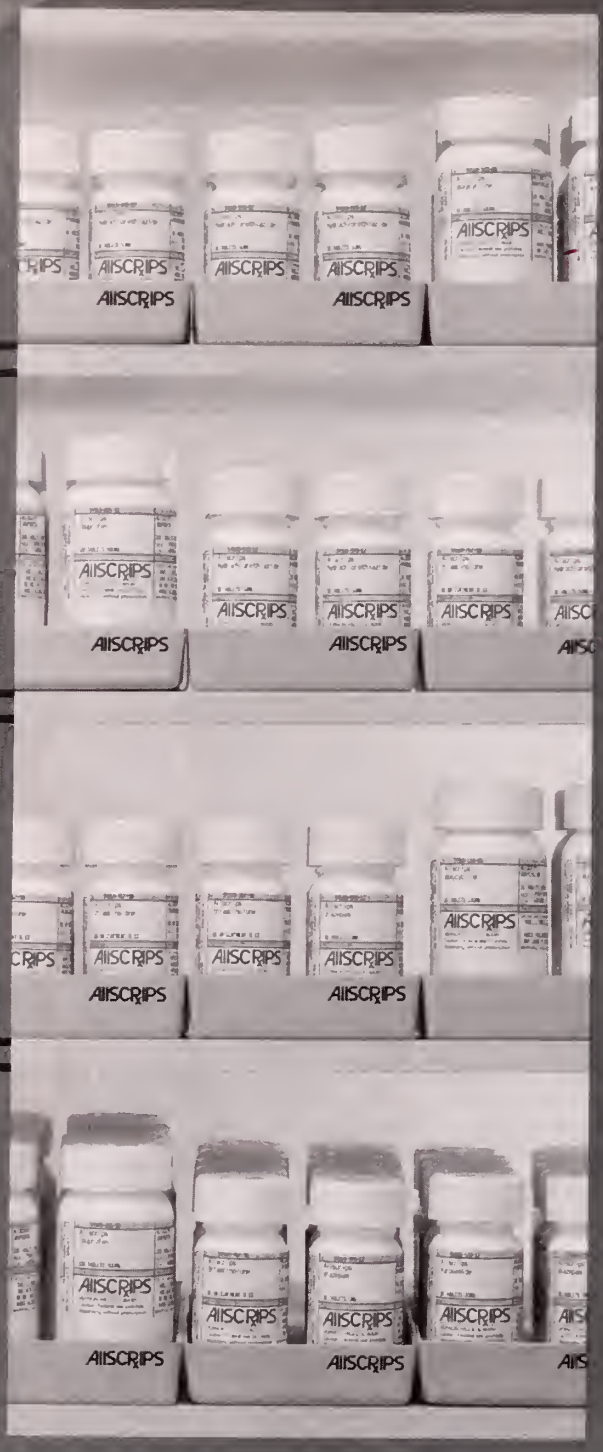


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Tort reform: girding for the next battle

Physicians in Florida once again got seized by a cold and clammy feeling when the state Supreme Court, in issuing its decision to the challenge by insurance companies on the 1986 Tort and Insurance Reform Act, declared the cap on noneconomic damages as being unconstitutional. The decision delivered another devastating blow to the efforts by physicians and other groups to seek a solution to the steadily worsening professional liability crisis. While many physicians felt that a cap of $450,000 would not have helped much to stabilize the situation, it was at least a start, with the prospect that the amount could be capped further in future legislation. Now the court is telling us to forget the whole thing, reasoning that a cap violates the rights of individuals to constitutional guarantees of access to court or to a trial by jury.

This decision by the Florida Supreme Court only reinforces a deeply held suspicion that physicians, in their fight for tort reform, will not get any relief before the state tribunal. Many physicians will remember that it was the same court which declared mediation panels as unconstitutional after two previous unsuccessful challenges by the Florida trial bar. Then in 1984, the same court again declared a referendum for tort reform unconstitutional after thousands of Floridians made clear that they wanted the referendum on the ballot.

FMA President Dr. James Perry echoed the anger and bitterness of thousands of Florida physicians when, at a press conference on May 4 in Tallahassee, he blasted the state Supreme Court decision as irresponsible and contrary to public interest. Dr. Perry cited the fact that many states have similar and far more stringent caps and yet are not deemed to be unconstitutional, and that the Supreme Court of the United States itself had ruled on a similar cap in California as being constitutional. In the face of these precedents, it indeed strains credulity to think that the Supreme Court here would come up with such an aberrant ruling.

The offshoot of the ruling is that physicians are back at where they started: ground zero. No attempt at tort reform can succeed without any limitations to the unconscionable awards that are being handed out by juries and judges. Multimillion dollar awards have driven professional liability premiums sky-high and unaffordable to a substantial number of physicians, inevitably leading to more expensive medical care and limitations in the access to certain medical services. The recent situation in south Florida where a number of high-risk specialists had to suspend or limit their services in emergency rooms and trauma centers is a harbinger of things to come unless something is done to avert what potentially is looming to be the worst professional liability crisis yet.

What is already a critical situation can only get worse with the recent announcement by St. Paul Insurance Co. and CIGNA that they will be pulling out of the market by July this year. That will leave some 8,000 physicians scrambling for cover. Insurance Commissioner Bill Gunter and the legislature in Tallahassee, as usual, have come up with stop-gap measures to stem the crisis, but neither one of the two proposals addresses the root of the problem, and both of them will perpetuate the deep pockets which have made the tort system such a gold mine for lawyers. It must be fairly obvious to all now that the way to a permanent solution to the liability problem may not lie a with a recalcitrant legislature. When one key legislator had the gall to suggest that the FMA was trying to manufacture a crisis to force legislators to enact laws favorable to physicians, and when another arrogantly called for disbanding the academic task force created in 1986 because it was building a ". . . case to do away with the tort system," physicians realize all too well the formidable obstacles they must face.

Dr. James Perry and the FMA Board of Governors met on May 13 in Tallahassee with county medical society officers, executive directors, representatives of

specialty groups, and FMA Auxillary leaders to review recent developments and to explore what to do next to counter the recent Supreme Court ruling as well as to continue its legislative efforts for meaningful tort reforms. The Board decided, among other things, to reaffirm its endorsement of the "Barron Plan" and to get it enacted at this year's legislative session, to continue efforts for a constitutional initiative aimed at capping nonecomomic damages to $100,000, and to approve a policy statement concerning insurance availability for physicians.

The Barron Plan, which is structured along the lines of the state workers' compensation law, contains features that will eliminate many undesirble elements of the present tort system. But whether the Florida legislature is willing to adopt the plan is another matter. To be sure, the FMA will continue with current efforts in the legislature to ease the liability crisis and to enable physicians to continue to provide medical care to indigents and emergency room patients. The public should not be victimized by a system which has forced some of the most highly trained physicians in Florida to limit or withdraw their services because of excessively priced premiums.

It is extremely frustrating for physicians to realize that they will have to start all over again. It is clear, however, that the present crisis was spawned not by lack of leadership in the FMA, nor by lack of militancy by physicians in general, but by an unfriendly legislature and an unsympathetic state Supreme Court which thwarted all past attempts to bring meaningful reforms to the tort system. Now we need to gird for the next battle and possibly bring our case again directly to the citizens of Florida. More than ever, the public needs to get educated about the critical nature of the problem, about the urgent need for reforms, and about the potential problems in access to medical care if nothing were done to change the system. The aborted 1984 constitutional initiative proved that physicians have broad-based public support. We must capitalize on that goodwill and put an end once and for all to a system that has gouged the public far too long.

R. G. Lacsamana, M.D.
Editor

When will society let medicine come in out of the cold?

Medicine has usually occupied a privileged status in whatever society it has been a part of. This has afforded certain privileges of which most people are aware, such as high economic status, social position and respect. Those who have practiced medicine over the centuries have felt that they were an integral part of their respective societies and indeed helped to mold the intrinsic values of that society. In turn, the society helped to mold the path of medicine as it did other professions such as law, etc. To sociologists and historians, this represents a natural order of things and one which has evolved in all societies over multiple generations. Events of society which may be political economical or religious as well as medical helped to mold that society into a cohesive whole which was pliable enough to take all segments of the society into its sphere and make them all a part of the overall picture.

Law is the one profession in America where the influence of society can be clearly seen. Legal authorities like to point out that the law is a fluid discipline, constantly in flux and changing with the morals and directions of society. The Supreme Court decisions of the 1850s and early 1890s upholding segregation would not be a reasonable expectation in the 1970s and 1980s. Much of the landmark legal opinions on regulation of railroads, corporations and trusts came during a period of great social unrest and public demand for reform. The legal authorities are correct. The law is a vibrant, living entity that must be constantly analyzed and viewed in the context of society as a whole. This has been good for the law and good for the citizens of this country.

On the other hand, medicine has never really been a part of society to the extent the law has. Perhaps this is inevitable. In medicine, out of necessity, much of the emphasis has been on the scientific approach which is inflexible in most cases. However, as we all know, there is a part of medicine which is not scientific and which we call "the art of medicine." This is the part which has kept us as a part of society and which is changing and flexible. Ironically, as the age of technology came upon medicine, the art of medicine has lost prestige and as a consequence medicine has lost some of its relationship with society as a whole.

The role of medicine to society has often been one of wariness and sometimes a distrustful relationship in the past, not only in America but also in Europe. This segregation of medicine from society is not as pronounced of course in our present world, but there is still a division and this has led to trouble for medicine. Many of the problems which now plague medicine are problems of society as well and should be solved as society's problems, but this is not the case. Let me illustrate my point. The problem of organ transplantation and selection of recipients is a growing one in the United States and shows no signs of abating. At the present time, the system has little direction with the recipient being helped by pleas from the President of the United States or other prominent personalities if he is fortunate enough to gain this help. However, in many cases, the medical

system gets the blame for the systems when in reality it is not the place of medicine to make the decisions ultimately. They should be made by all facets of society including theologians, legal authorities, politicans, economists, and physicians.

The same scenario can be seen in the raging argument over whether it is morally responsible to spend $100,000 on a heart transplant or whether that money should be spent to help prevent heart disease or when is it moral and ethical in medicine to terminate care for a patient who has little chance of any quality life?

These are the issues which all of society faces and yet most people feel that medicine is the entity which makes these decisions. The disturbing factor in this equation is that medicine is held responsible yet it is not medicine which makes the decisions—and should not be. It is difficult to find out who makes the decisions in these very difficult situations. Often, no one can tell how the decisions were made, they just seem to happen.

Of course, the obvious answer to the dilemma of society and medicine is through state and federal government with input from medicine and other disciplines to decide on a logical and reasonable course of action. If medicine were an integral part of society this would have happened, but that is not the case. It is not the fault of medicine because medicine has tried to integrate itself and work within the guidelines of government fiat with Medicare, Hill-Burton Act, etc., but society, including the government, has really not wanted us to be brought "too close" as some of the blame which has been directed at medicine may be therefore directed at other segments of society.

It is to the advantage of the federal government and others who may be held accountable for "decisions not made" to distance themselves from medicine, create the atmosphere and illusion that it is medicine that the criticism should be directed. It is to medicine's disadvantage that this attitude should persist and ultimately it is to society's disadvantage because, like law, medicine should be an integral part of society, changing and molding itself as part of the whole.

Those who attempt to isolate medicine from the rest of society in order to have a strawman to direct criticism at are taking a shortsighted approach and are destined to hurt our society and the medical care of its citizens.

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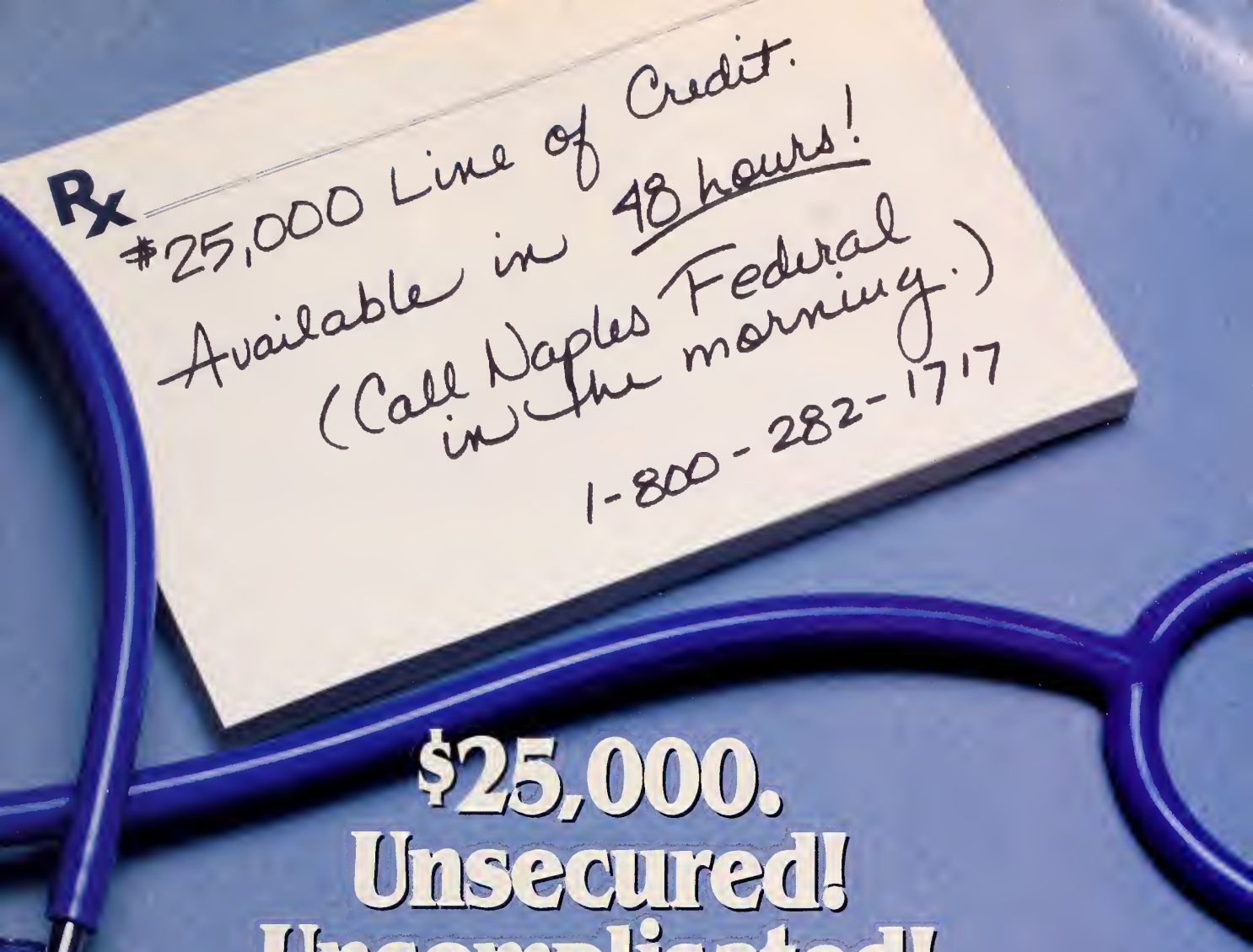
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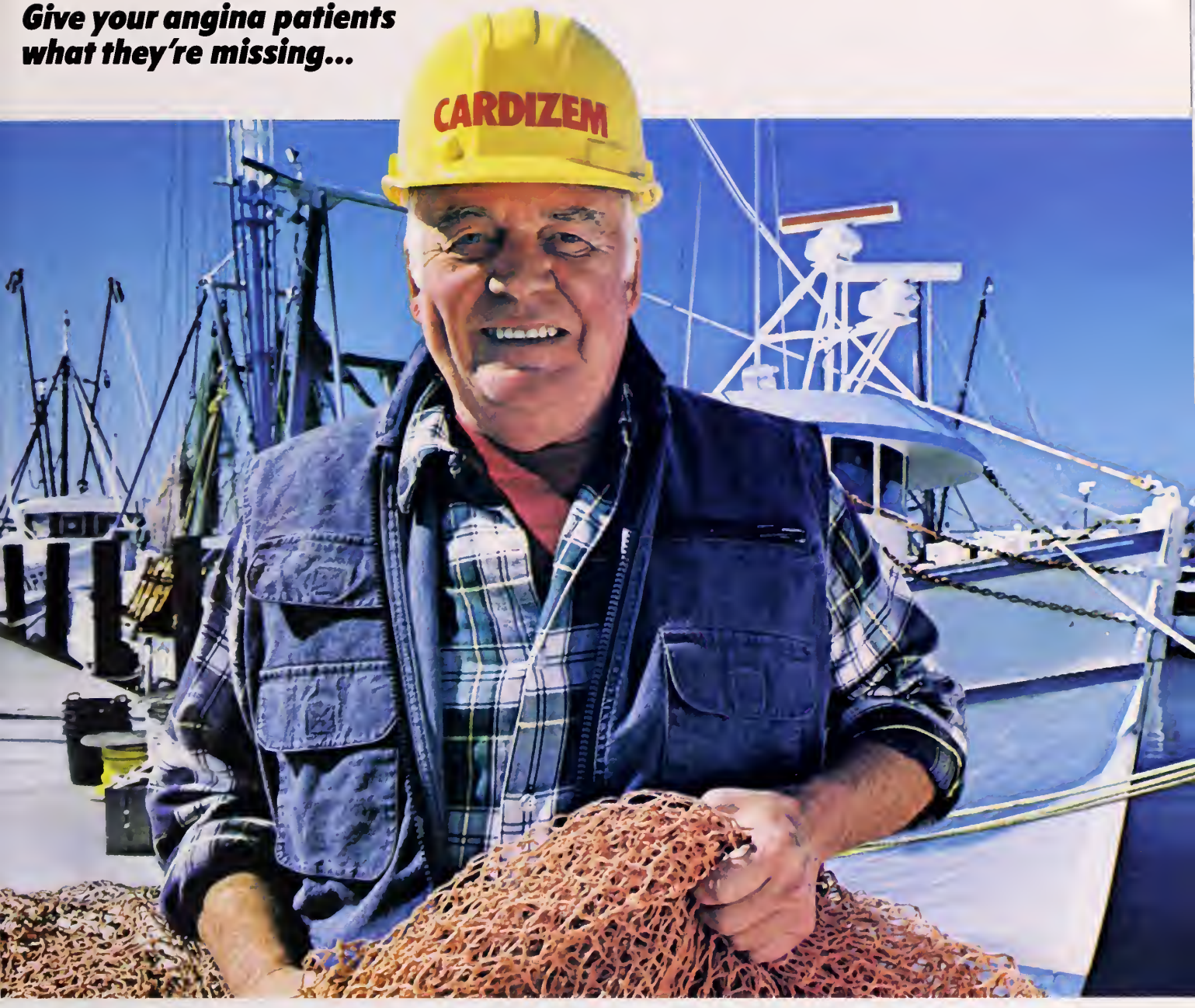
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CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

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References: 1. *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* **2.** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* **3.** *Johnston DL, Lesowoy R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687.* **4.** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* **5.** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982,50(Sept):94-116.*

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HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Revised, April 1982. 5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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FMA: World of strangers?

The Florida Medical Association (FMA) is many things. It is a geographical location. It is a state medical entity. It is an administrative unit with various relationships to other administrative units. FMA is a magnet—a place of hope to achieve coherent and enlightened action. It is a repellent—an inconvenience to a very small number of members. FMA is also a world of strangers.

The term stranger, in its popular as well as its scholarly uses, has a variety of meanings. It is often used to mean anyone with whom we are not acquainted, whom we have never met, even though we may possess a great deal of biographic information about the person. The term stranger is used here in a more philosophic sense to suggest separateness.

FMA because of its size is the locus of accretive problems. The vast majority of the members are strangers to each other. Most know of the aggregate existence of others but do not know of their individual existence. FMA is a world of strangers, a world populated by physicians who are generally and personally unknown to one another.

With the emergence of large medical associations of over 1,000 members there are problems of coping with strangers and experiencing anonymity. What to do about the inactive strangers is a source of much gymnastics in the "seats of the mighty" in the state and large county medical associations.

It has been claimed that large medical associations like the FMA impose upon members more restraints, regulations, procedures and other forms of coercive control on the grounds of maintaining stability and effectiveness. To this writer, associations' controls are essential for the systematic understanding of a physician's dynamic interaction with his environment. The business of a physician is to be concerned with the totality of man and with the health, the stability and effectiveness of the human society as a whole.

There has been criticism that participation in the legislative and administrative activity of county and state medical associations is merely exercises in exploitative, manipulative and competitive power. In the face of the pain and difficulty of transforming FMA's world of strangers, it is perhaps not surprising that many of the past FMA leaders attempted retreat; retreat into dreams of somehow "recreating" the strangeness into a binding brotherhood and sisterhood of solidarity.

Being a member was in the past enough but this is not the case now in an association as large as FMA. Nonactive, nonconcerned and noncommitted FMA stranger, is your apathy overt innocence that you are not needed? Being of a minority ethnically or being a foreign graduate should not be an excuse for withdrawal from participating in FMA's activities.

There is an ancient belief that at the end of a certain period the eagle molts and by some unknown means renews its youth and soars to the heights. Senior FMA members, you too can soar to heights unknown and bring forth fruit in older age and be full of sap and green. You are needed again to be intensely and fervently involved.

Additional academicians should be more active in the FMA. Their intellectual rigors, rational thoughts and empiricisms are needed to develop more effective methods for alerting our indifferent members. Individualism can coexist with FMA and preserve the consciousness of the individual and also maintain the element of interpersonal responsibility of solidarity. Solidarity can keep us alert, keep our imaginations functioning, keep us forever curious and

ready to explore infinite possibilities.

We must cut through barriers to initiate a relationship with the strangers in FMA. Affirmative, assertive and effective action is needed as too many strangers are entrenched with apathy and inertia. We must jar the strangers and not permit their consciousness to sleep.

If a medical association has only its by-laws, mores and its "established ways" and no input by its growing silent majority of strangers—to fertilize its growth, it can only stagnate in passivity and apathy. FMA needs enlarging insights and visions from all its members for its evolution.

There are sharks circling in the troubled medical waters. There is a government and third parties' feeding frenzy going on. There is an attack-dog mentality going on to end the fee-for-service concept in medicine.

The silent majority of strangers in the FMA can no longer justify their inactivity. The present state of affairs cannot be remedied by the majority of physicians remaining insulated from reality.

The silent majority of strangers in the FMA can help regain the dignity and power of the profession and could vehemently thrust forward as an entity charged with energy and structure in specific ways that would have no expressions of weakness and self-negation.

The FMA should address itself to immediate specific programs to develop effective methods to correct the separateness that now exists with "strangers in the midst of strangers."

The FMA's World of Strangers must end and with its new wellsprings of human spirit, it could be possible for the Florida Medical Association to be organized of, by and without question by physicians.

Edward Pedrero Jr., M.D., Ph.D.
Tampa

Editor's comment: I must disagree with my colleague. The FMA is not a world of strangers. The FMA, it is true, has grown quite big but it has managed successfully to accommodate all its component medical societies into its ranks philosophically united with one voice, pursuing the same goals, and confronting the same issues and problems. The FMA Board of Governors has opened its quarterly meetings to county medical society presidents and other physicians interested in having their voices heard. Physicians who attend the annual FMA meeting and other FMA-sponsored meetings and seminars meet not as strangers, but as friends sharing the same goals and concerns. At the grass-roots level, the FMA has gotten close to its members by periodic appearances of FMA officers at various county medical societies, by opening of hotlines to the central office in Jacksonville, and by distribution of such publications as *E.T.*, *FMA Today, and The Journal of the Florida Medical Association*.

The FMA is open to everybody, native and foreign medical graduates, old and young, male and female, although that is not to say that everybody will troop in to become members. I can only say that those who have not become members are missing many things. The FMA is not a world of strangers; it is a world of friends and dedicated physicians working to promote the commonwealth and the goals of the profession.

How to improve our image

I enjoyed reading Dr. James Perry's column on medical ethics and the malpractice problem. He is obviously correct when he stated that the layman's view of the physician has changed over the ages. Unfortunately, as we have become able to do more for the patient in a scientific manner, we have all too often been doing less in a humanistic manner.

For example, house calls have become increasingly impractical as the amount of equipment needed for accurate diagnosis has increased. Also the geographical area covered by most physicians would mean an inordinate amount of time wasted in travel. Unfortunately, a great deal of personal contact with the patient and his family is lost.

I remember our family doctor as a friend and neighbor. He also took me on my first fishing trip, ate at our house, came to our parties, etc.

Since simply wishing for the "good old days" is a fruitless exercise, let us try to think of ways that can bring back at least some of the old closeness. My own list of suggestions follow:

1. Respect the patient's time. One of the most frequent complaints I hear concerns long waiting periods for scheduled appointments. While occasionally one gets off schedule because of an emergency, many doctors "overbook" and are chronically late. If a scheduled patient fails to show, this means a loss of income, but most patients rightly consider their time as valuable as the doctor's.

2. Allow enough time for each patient. Your last statement should be "Any more questions?" Another common complaint is that, "the doctor was in such a hurry, I never did get to ask about . . ."

3. Accept Medicare or other insurance assignments for patients with a modest income. The Connecticut State Medical Society has a voluntary proram to accept Medicare reimbursement for elderly patients whose annual income is under $15,000. A similar program would do wonders for our

public image in Florida. Furthermore, we should act before we are forced to do so by governmental fiat.

We must begin to improve our image. Perhaps these and similar ideas will elicit a more sympathetic response from the patients when we need them in our corner to combat increasing governmental interference in the practice of medicine.

L. Jerome Krovetz, M.D.
Plantation

Obstetrician offers idea to ease insurance crisis

As an obstetrician and gynecologist, I feel it is possible that the present malpractice insurance crisis for those in our specialty could be resolved if Florida attorneys agree to the following scenario.

Obstetrical patients, especially those considered high-risk, should early in the pregnancy contact not an obstetrician but rather a malpractice attorney. He, in turn, would then select from his file of high-quality expert witness obstetricians and gynecologists one who does not deviate from the standard care espoused by the malpractice attorneys.

With this level of care so carefully monitored during the entire pregnancy by both the obstetricians and the attorney, the patient would obviously be receiving the best care possible, there would be no mistakes made and bad results would be eliminated.

In fairness, the malpractice attorney should be allowed a fee commensurate with that of the obstetrician's.

The idea, if implemented, would do much to reduce the exorbitant insurance premiums and would allow the average obstetrician to spend more time caring for his patients instead of sitting in the courtroom.

Matthew J. Bulfin, M.D.
Fort Lauderdale

Reprinted with permission from the *News/Sun-Sentinel*, March 28, 1987.

Patient's search for a doctor criticized

I read the short article under your "Encores!" section entitled "I cannot get medical care," page 45, Vol. 74, No. 1, JFMA of January 1987. I believe that this short piece is mistitled. More accurate editing would have titled the piece "I don't know how to pay for medical care." The authoress paid $160 of an estimated medical expenditure of $1,520 leaving her facing a bill of $1,360 or three months of current income. She concluded that she "simply cannot afford it."

What an individual thinks that she can or cannot afford is a subjective decision not entirely based upon the number of dollars in her purse. Most American adults driving automobiles, renting or buying housing, purchasing insurance, toting credit cards, taking cruises and vacations, romancing or being romanced by the opposite sex, and undertaking obligations for medical and surgical care beyond the trivial have obligated themselves for more than three months of current income. This writer probably would benefit by being referred to a financial counsellor who could teach her how to evaluate her present and future financial capabilities, and how to deal with future economic needs and wants. Physicians and medical facilities are not famous, for good reason, for their financial expertise and sophistication. Indeed her physicians did this patient no favor by providing surgical therapy without charge. They left her no better off with respect to her understanding of and insight into the financial demands and opportunities of her future life.

Allan Erde, M.D., P.A.
Winter Haven

Author's response: I am somewhat at a loss on how to best address Dr. Erde's concern about the poor financial planning of the patient in question. I do not think that the patient would really benefit or be satisfied by the approach which Dr. Erde suggests. The point of the article was to show that regardless of good intentions, there are people who fall "through the cracks" in our medical system. The authoress certainly fits in the category as do many others. For these persons, no amount of scolding or financial counseling will solve the problem.

I disagree with Dr. Erde's assertion that adequate financial planning and a reprioritization of values would take care of the problem. In his letter, Dr. Erde indicates that he feels that three months of income is not excessive for the needed surgery. While the overall cost may not be excessive, three months of anyone's income for a relatively common operation does represent a lot of money from anyone's viewpoint. The average physician's income is approximately $80,000 per year and I suspect most of us doctors would have a hard time swallowing a fee of $21,000 for an appendectomy or hysterectomy.

I think that readers of this first person account would be better served as well as the world of medicine and the care of patients, to view the patient's dilemma as an aberation of the medical system and to work to see that these situations do not arise.

H. Frank Farmer, M.D.
New Smyrna Beach

Thanks and thanks

The American Cancer Society, Florida Division, Inc., thanks the *Florida Medical Association Journal* for running one of our full-page ads in your March issue. The Division is extremely grateful for the terrific exposure which you provided.

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The Florida Division will be happy to supply you with any information which may be helpful to the journal.

Thank you for your contribution!

Gordon Towne, Chairman
Public Information Committee

Primary care — what's it all about?

"Mom, what's that strange rustling noise I hear?" I ask.

"I'm not sure but it could be your father rolling over in his grave," she answers.

"How so?"

"Young man, I'll tell you 'how so?' if you really want to know. You know how he felt about socialized medicine and now you're getting involved."

"Mom, wait up a minute. If Dad were alive we'd ask him why he 'caved in' and began taking assignments when he had originally said 'I'll never take an assignment' but he finally did for Medicare and also Medicaid."

"Bob, look, you know he had to. His only way to make money at all on some of those folks who had been unable to pay him was from Medicare."

"Maybe, Mom, just maybe primary care is a similar situation. Maybe if you'll give me that private practice has no need to feel threatened and primary care is not competing with private care but is complementary and also there are a lot of folks out there that need to be seen and have no insurance to pay for medical care (kinda like Medicare when it first started) nor do they have any money either—do you think Dad would go along with it?"

"I think maybe he would since you explained it to me and if he were here you could have explained it to him. Bob, I think that rustling you mentioned was just the wind blowing through the trees. Yes, only that and nothing more."

The above is a hypothetical situation, of course, but let me assure you it is not that far fetched. My father was a GP in a small town in Alabama for 30 years and mother was his office nurse the entire time. Were he alive and got "wind" of the primary care concept in Florida I would refer him to the entire *JFMA*, February 1987, Vol. 74, No. 2, that dealt with "Indigent Health Care". I would tell him to look real closely at Dr. Conn's article (pages 120-124.). Then I would ask him to critically read Gary Clarke's excellent article on the subject in *JFMA*, April 1987, Vol. 74, No. 4, pages 269-278.

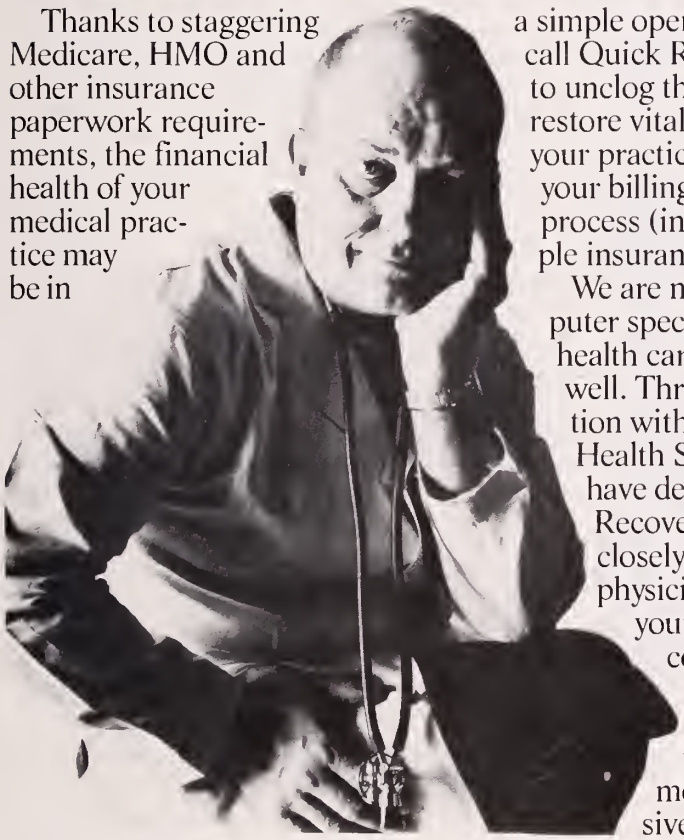
The above cited journals and articles are truly excellent and should be read by every Florida physician.

"Come on, Wilson, you're in public health—of course you think they're great, but what about me out here in 'the trenches,' what is there for me to like?"

Friend, I was in the trenches too for a long time so I know how it is. Believe me there is nothing to fear. Sure there will be some exploitation; I know there is no perfect system. Sure, there will be some who could afford private care and may opt for the state program. By and large, my friend, the good outweighs the bad by mega amounts.

Robert K. Wilson Jr., M.D.
Medical Executive Director
Escambia County Public Health Unit
Pensacola

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION INC
MAY 1987, Vol. 74, No. 5

CA-125: an evaluation

R. Nuss, M.D., G. Michael Swor, M.D., and G. Benrubi, M.D.

ABSTRACT: Recent data suggest a correlation between CA-125 monoclonal antibody radioimmunoassay level and the clinical course of certain ovarian epithelial carcinomas. In retrospectively evaluating the course of 37 patients at the University Hospital of Jacksonville's gynecologic oncology service, an attempt was made to compare the results of CA-125 levels with traditional clinical evaluation in patients undergoing a standard therapeutic regimen and/or posttreatment follow-up. Results suggest that (1) CA-125 is a more sensitive predictor of recurrence and persistence than standard clinical methods, (2) when CA-125 is elevated, in almost all cases disease will eventually be documented, and (3) normal CA-125 levels do not preclude presence of disease. It appears that this relatively inexpensive noninvasive laboratory assessment has a place in the management of epithelial ovarian cancer.

The Authors
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Traditionally, ovarian epithelial carcinoma has been a frustrating disease in respect to delayed diagnosis and suboptimal clinical monitoring capability. Newly developed assays for tumor associated antigens have shown promise as aids in monitoring certain cancers including most recently specific carcinomas of the ovary.[1] Secreted in the bloodstream by tumor cells, this new antigenic determinant is known as CA-125, and a radioimmunoassay using monoclonal antibody is available. Previous studies[1,2] have suggested a high degree of sensitivity and specificity to serous, endometrioid, undifferentiated and clear-cell epithelial ovarian tumors of varying grade. In addition, clinical correlation of CA-125 levels with those patient's therapeutic response has been demonstrated preliminarily.[1,3] Our aim was to further evaluate and compare the effectiveness of CA-125 levels as an accurate and sensitive monitoring parameter in relation to traditional clinical modalities such as abdominopelvic examination and computerized axial tomography.

Materials and methods • We retrospectively analyzed the clinical courses of 41 selected patients of the University Hospital of Jacksonville's gynecologic oncology service. This group included all patients in whom CA-125 levels were obtained as part of their evaluation either at the time of diagnosis, during standard therapeutic courses, or in posttreatment follow-up.

Of four patients excluded from the study, one was lost to follow-up, one had squamous cell carcinoma of the cervix, one had adenocarcinoma of the endometrium, and one had a mixed mullerian mesodermal uterine tumor.

Of the 37 remaining patients, two groups were formed. Group I included 19 patients in whom

CA-125 levels were obtained at time of diagnosis and/or through a standard therapeutic course (generally forms of traditional chemotherapy). Group II included 18 patients in whom evaluation of CA-125 levels was done during posttreatment follow-ups as a parameter for monitoring recurrence. The 37 patients were diagnosed with various stages and histologic types of ovarian epithelial cell cancer as summarized in Table 1. All were followed through the period of February 1984 to March 1985 with traditional clinical evaluation including abdominopelvic examination for tumor mass, computerized axial tomography and biopsy, or surgical findings. Diagnoses were confirmed with review of medical records including operative notes and pathologic reports. Histologically, there were two borderline carcinomas, three unspecified ovarian cancers and 32 adenocarcinomas, of which eight were serous, five endometrioid, one clear cell, and 18 unspecified. There were nine Stage I tumors, five Stage II, 20 Stage III and two diagnosed as Stage IV with one patient's stage undetermined. One to seven CA-125 levels were drawn on each patient over a period of up to 12 months. Six patients had additional diagnoses of concomitant disease (Table 2) including two with benign liver disease, one with previous cervical carcinoma, one with previous breast carcinoma, one with both breast and endometrial malignancies and one with associated endometrial cancer. Data collection and analysis were performed by one investigator not principally involved in the care of the subject patients.

CA-125 radioimmunoassay (RIA) level was performed by Smith-Kline Laboratories in Tampa, Florida, with serum generally collected by a nurse oncologist or laboratory technician at University Hospital. Abbot CA-125 RIA system was used according to manufacturer's instructions. Values were measured in u/ml with normals being considered ⩽35. A 20% change (either increased or decreased) was considered significant, which should be well within margin of error of the test, according to Abbott Laboratories coefficient of variation testing. For definition purposes, response to therapy was considered to be a 50% decrease in two dimensions in clinically evident tumor mass with lack of new growth or metastasis. Progression was considered clinically appreciable increase or insignificant decrease in tumor bulk, evidence of new metastasis, or death secondary to the disease.

Table 1.—Stages and Histologic Types of Ovarian Epithelial Cell Cancer.

Histologic Type	Number
Borderline Carcinomas	2
Adenocarcinomas	32
Serous	8
Endometrioid	5
Clear Cell	1
Unspecified	18
Unspecified Ovarian Tumors	3

Stage	Number
I	9
II	5
III	20
IV	2
Undetermined	1

Table 2.—Concomitant Disease.

Previous cervical cancer (postirradiation)
Hepatitis
Endometrial adenocarcinoma
Endometrial adenocarcinoma Breast carcinoma
Endometrial adenocarcinoma
Hepatic cirrhosis
Breast carcinoma

Results • In the 19 Group I patients, 15 exhibited clinical evidence of response and in four disease was noted to progress. Fourteen of 15 responders exhibited decreasing to normal or normal CA-125 levels. Two or four nonresponders had increasing and/or elevated CA-125 levels. In the 18 Group II patients four clinically recurred, all of whom had elevated CA-125 levels. Ten of the 14 clinically free of disease had normal levels of CA-125 (Table 3). Noncorrelating cases are presented in Table 4.

One patient in Group I demonstrated increasing to slightly elevated CA-125 levels during chemotherapy (up to 45 u/ml). Contrary to the CA-125 levels, clinical findings were consistent with good response. However, during short term follow-up, recurrence became evident clinically (documented surgically) and CA-125 levels rose to 335 u/ml. Two patients demonstrated apparent progression clinically with decreasing to normal or normal CA-125 levels. Of these patients one had a positive chest roentgenogram consistent with metastasis, although biopsy was insufficient for diagnosis. The CA-125 levels drawn after radiation therapy to her concomitant primary ovarian and endometrial adenocarcinomas were 22 u/ml and 19 u/ml. After empirical chemotherapy, follow-up chest x-ray was normal and she now has no evidence of disease. These two patients illustrated apparently better accuracy of CA-125 levels than other clinical parameters, although no elevated CA-125 level was ever obtained in the latter. The second patient with clinical progression

Table 3.—Patients Clinically Free of Disease.

Group I — Therapeutic Response

19 Patients

Traditional Parameters Indicate:		CA-125	
		Normal or decreasing to normal	Increasing and/or elevated
Response	n=15	14	1
Progression	n=4	2	2
	19	16	3

Group II — Evaluation for Recurrence After Therapy

18 Patients

Traditional Parameters Indicate:		CA-125	
		Normal	Elevated
Free of Disease	n=14	10	4
Recurrence	n=4	0	4
	18	10	8

and normal CA-125 levels had only two levels drawn (both <11 u/ml) and these were taken during chemotherapy with hexamethylmelamine for Stage III serous cystadenocarcinoma. She expired from recurrent disease noted surgically two months following a normal level and one month following a positive CT scan.

In Group II patients, four of 16 exhibited increasing or elevated CA-125 levels contrary to being clinically free of recurrence. However, one patient had concomitant breast carcinoma. Although free of disease clinically after chemotherapy, the CA-125 level was 80 u/ml. A second patient from Group II, with Stage III adenocarcinoma of the ovary, had multiple previous recurrences and although without evident disease had a most recent level of 36 u/ml. The third patient had Stage II ovarian adenocarcinoma and no evidence of disease but increasing (to 63 u/ml) CA-125. At the same time surgery confirmed progressive recurrence and the patient subsequently expired. The fourth Group II noncorrelating patient had a negative CT scan and physical examination but elevated CA-125 (192 u/ml) with recurrence documented surgically one month later. Interestingly, of the nonovarian cancer patients excluded, both patients with the endometrial and cervical lesions had single normal CA-125 levels while the mesodermal uterine tumor patient had serially decreasing CA-125 levels from an initial high of 506. Except for the patient with breast carcinoma and an elevated titer despite clinical response, concomitant disease did not seem to be a factor in the accuracy of the assay Contingency coefficient (phi) for correlation between traditional clinical parameters and CA-125 levels was 0.577 ($p<01$) in Group I and O.677 ($p<.004$) in Group II.

Discussion • Previous studies have suggested high correlation between CA-125 levels and clinical course of certain ovarian epithelial tumors.[1,3] Ricolleau's results were predictive in 15 of 18 patients (83%). Bast demonstrated positive correlation in 42 of 45 patients or 93%. We have results suggesting a positive correlation in 30 of 37 (81%) patients studied, when comparing CA-125 predictive value to other traditional clinical parameters.

Results from Group I suggest that normal or decreasing to normal CA-125 levels appear to be highly predictable in tumors that respond to therapy. Especially sensitive appears to be the prediction of recurrence by rising levels of CA-125 as shown in Group II. Improved sensitivity might be further obtained by baseline reactivities performed at the time of diagnosis.

In at least three (and more likely five) of our total of seven noncorrelating cases, the eventual outcome would suggest that CA-125 levels were more accurate in predicting the actual course of disease. After combining these cases with parameter-consistent cases, we improve our clinical correlation with CA-125 levels to 92% (34 of 37 patients). It would appear that CA-125 levels, when used to monitor patients with epithelial ovarian tumors, are a useful adjunct to traditional methods of assessing tumor activity. Aggressive diagnostic testing and therapy in the clinical presentation of markedly elevated CA-125 levels alone (> 65 u/ml), with or without other clinical evidence of progression, seem to be prudent. Bast suggested that no durable regression of disease was noted if CA-125 did not fall below 35 u/ml during therapy.[1] Our data support that conclusion. Convincing data[1,2] indicate that greater than 80% of ovarian epithelial cancer patients will have elevated CA-125 levels (> 35 u/ml).

Table 4.—Noncorrelating Cases.

Group I	Diagnosis	Clinical Findings	CA-125	Outcome
1	Stage III adeno CA ovary	Good response	Increasing to 45	Tumor progression documented surgically
2	Stage III adeno CA ovary Stage IB adeno CA endometrium	Apparent lung mets by chest x-ray	22/19	No evidence of disease; Follow-up chest x-ray neg. after empiric chemotherapy
3	Stage III serous cyst-adeno CA ovary	Progression (noted late)	10/11	Progression noted surgically
Group II				
1	Stage I adeno CA ovary; Stage II adeno CA endometrium recurrent breast carcinoma	No evident tumor	80	No evident recurrence
2	Stage III serous cyst-adeno CA ovary	Good response	Increasing to 36	No evident disease (history of multiple recurrences)
3	Stage II adeno CA ovary	Good response	Increasing to 63	Recurrence later
4	Stage II adeno CA ovary	No evident tumor	Increasing to 192	Recurrence later

Therefore, statistically less than four or five of these patients would be expected to have tumors with negative reactivity for CA-125. Conversely, one noncorrelating case could be explained by this weakness.

We, as others, found no significant correlation between initial stage or grade of tumor and CA-125 level.

Noted also was that of seven patients with concomitant disease, including benign liver disease, breast cancer and other gynecologic malignancy, only two exhibited any elevated CA-125 levels (Table 4). Klug has suggested that with these types of associated conditions 98% confidence levels could be maintained using a normal limit of 65 u/ml.[2] Bast additionally indicated that values > 35 u/ml would be found in 1.4% of apparently healthy females, 6.3% of patients with benign diseases and 12% of breast cancer patients. Klug also calculated that in females at risk, ages 45-74, CA-125 levels > 35 u/ml corresponded with a 5% chance of having ovarian carcinoma, and > 65 u/ml corresponded with 14% risk. The higher limit corresponded with a 47% risk for any type of carcinoma.

The data presented are consistent with the most recent reports,[6-10] and add to the body of evidence suggesting that the monitoring of CA-125 levels has a place in the care of patients with ovarian carcinoma. It provides a noninvasive, sensitive, somewhat specific and relatively inexpensive parameter to predict response to therapy as well as recurrence. Further prospective studies are indicated, especially for analysis of CA-125 as a screening test.

Conclusion • CA-125 is a more sensitive predictor of recurrence and persistence than standard clinical methods. When CA-125 is elevated, in almost all cases disease will eventually be documented. Normal CA-125 levels do not preclude presence of disease.

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Maternal serum alpha fetoprotein screening project

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ABSTRACT: Testing of maternal blood for alpha fetoprotein concentration has become increasingly widespread in the United States. Successful utilization of such testing depends upon adequate interpretation of results and availability of follow-up testing. Checklists are provided for health care providers shopping for such services.

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Although maternal serum alpha fetoprotein (MSAFP) screening has been an established part of antenatal care in Great Britain for some time, widespread use in the United States is a relatively recent event. Earlier acceptance in Great Britain was due not only to a higher incidence of open neural tube defects (NTD) with a subsequently greater yield, but by the greater degree of organizational structure inherent in the British system of obstetrical care. During the 1970s the lower rate of NTD in the United States along with concern for the proper interpretation and follow up required for effective MSAFP programs led many to question their value.[1]

A change in utilization of MSAFP testing in America has been brought about by several factors. Firstly, several pilot programs demonstrated that MSAFP screening programs were applicable to the American system of medical care. Such programs reliably detected a significant number of NTDs without causing undue morbidity due to false positive diagnoses.[2-4] Secondly, the role of MSAFP testing began to expand. Reports dealing with the outcome of pregnancies with elevated MSAFP demonstrated that such testing might be a useful tool in early indentification of pregnancies at high risk for a number of adverse perinatal events.[5] More recently it has been discovered that low MSAFP values are useful in the assessment of risk for Down's syndrome in the fetus.[6,7] Thirdly, and perhaps most importantly in widespread utilization of testing, was governmental approval of commercially available test kits. Such kits have allowed laboratories to perform AFP testing without the intensive effort required for independent production of required materials and assay standardization. Finally, although unfortunate, the coersive force of possible litigation must be recognized.

With the exception of a few areas where MSAFP testing has been organized on a statewide level, the American health care provider faces a puzzling array of alternatives. Serum testing is offered by a variety of commercial laboratories, large programs which accept samples from wide geographic areas, local, usually university based programs, and a variety of combinations.

Many physicians have been placed in the position of having to decide between providers of MSAFP testing without reliable guidelines for what constitutes necessary or desirable features of the service. These features can be broken down into three separate components of a MSAFP screening program: laboratory testing, expedited reporting and communication, and provisions for women with positive screens.

Laboratory capabilities ● Laboratories involved in the determination of AFP in serum samples should assure that assays are run with strict attention to rapid test performance, and a high degree of quality control. All runs should include reference preparations to prevent a systemic error in assay. Nationwide quality control programs exist which allow laboratories to compare their results with the other participants in the program. The monitor of the program sends periodic performance reports to each laboratory. Providers should determine if a laboratory under consideration takes part in such a program.

Since the normal concentration of AFP in maternal serum rises throughout the period when samples should be obtained and is dependent upon maternal weight, race, and presence of diabetes mellitus, the laboratory must include standardization for these factors in the analysis.[7] As this and other clinical information is critical for accurate reporting of results the laboratory should provide appropriate request and data forms. Such forms should request at least the information contained in Table 1. Laboratories which do not request this information cannot optimally analyze the result.

Additionally, although not necessary, it is highly desirable that the laboratory has the capability for AFP testing along with determination of acetylcholinesterase and fetal hemoglobin in amniotic fluid as this facilitates the coordination between the laboratory and clinician and minimizes delay.

Reporting ● Health care providers are familiar with laboratory reports which provide the sample's value and a "normal range". The preferred method of MSAFP reporting is as multiples of the median. Since, as mentioned previously, the concentration of AFP is maternal serum varies with gestational age, the median used must be gestational age specific and adjusted for weight and other factors as outlined previously (Table 1).

Table 1.—Information Required for Proper Laboratory Evaluation of MSAFP.

Age	Race
Weight	LMP Date
Residence	Sample Date
Fam Hx NTD	Diabetes Mellitus
Sonogram Performed	Sample Number
Sonogram Results	

Sonography and amniocentesis ● Sonography is the most important tool required in the evaluation of the patient with a high MSAFP. To mitigate patient anxiety, it is preferable that a system of MSAFP screening include sonography and amniocentesis. This maximizes experience of the team and can reduce the burden to the private physician when especially faced with a "high" or "low" MSAFP level. In most of these cases a reason for the high value can be determined by a basic (Level I) examination. The goal of this examination is determination of fetal viability, exclusion of multiple gestation, confirmation of gestational age, and the detection of anencephaly. Since this level of ability should be met by anyone offering obstetrical sonography, availability should not be a problem.

For the relatively small group of patients who remain at high risk following Level I sonography, amniocentesis and advanced (Level II) sonography must be available. Since fetal blood contamination can seriuosly hamper the interpretation of AFP in amniotic fluid specimens, it is highly desirable that these samples be obtained under continuous sonographic guidance.

The range of fetal anomalies associated with elevations of AFP is broad enough to challenge even the most experienced obstetrical sonographer. In addition to open neural tube defects, hydrocephaly, cystic hygroma, ventral wall defects, intestinal obstruction, urinary tract anomalies, and fetal teratomas have been observed. The skills for adequate examination in this group are less widely available and must be frequently exercised to remain sharp. Obviously, a close association between the screening service and the sonographer is of great benefit to both as well as the refering physician.

Recommendations ● Armed with this list of requirements the primary physician can make an informed choice of programs. This is best accomplished with a checklist of questions (Table 2).

If the answer to all these questions is yes, then your decision can be based solely upon price. If the answer is no, or unavailable, it may be best to keep looking. You owe it to your patients and yourself to find the right answer for you.

Table 2.—Questions for Providers of MSAFP.

1. Are literature, sample and consent forms provided?
2. Are mailers or sample pick up provided?
3. Is there an additional charge for a repeat sample?
4. Are high or low results telephoned to the physician?
5. Are counseling and recommendations provided?
6. Are risks for NTD, VWD, etc., provided?
7. Does the laboratory submit to quality control evaluation?
8. Are the results based upon the population in your area?
9. Are race, weight and diabetes accounted for?
10. Does the lab test amniotic fluid for AFP?
11. Does the lab test for acetylcholinesterase and fetal hemoglobin?
12. Will results be recalculated after a Level I sonogram?
13. Is sonographically guided amniocentesis available?
14. Is competent Level II sonography available?
15. Is someone available to help you expedite management?

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Lambert-Eaton myasthenic syndrome associated with hypothyroidism and features of myasthenia gravis

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ABSTRACT: • *We describe a patient with Lambert-Eaton myasthenic syndrome (LEMS), hypothyroidism and features of myasthenia gravis. A 58-year-old woman complained of limb muscle weakness for three years. She also reported mild bilateral ptosis at the beginning of her illness. Physical examination revealed dry mouth, moderate proximal limb weakness, and hypoactive tendon reflexes. Laboratory studies showed low T4, elevated TSH, markedly increased microsomal antibodies, and absent serum acetylcholine receptor antibody. An edrophonium test done quantitatively was positive on two occasions. Treatment with pyridostigmine alone caused only mild improvement of muscle strength. Repetitive stimulation of the abductor pollicis brevis muscle was then performed showing 400% incremental response at the rate of 50 Hz. Treatment with guanidine alone caused marked improvement but normal muscle strength could only be obtained with combined, guanidine and pyridostigmine treatment. We suggest that in a patient with muscle weakness and positive edrophonium test but negative serum acetylcholine receptor antibody and only partial response to pyridostigmine, a search for LEMS should be undertaken. The association of LEMS with hypothyroidism in our case further supports the immunologic etiology of the former.*

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The Lambert-Eaton myasthenic syndrome (LEMS) and myasthenia gravis (MG) are two well known disorders of neuromuscular transmission. LEMS is characterized by proximal muscle weakness, depressed tendon reflexes, and autonomic impairment, including dry mouth. It may occur in association with carcinoma (usually oat cell), with autoimmune diseases,[1-5] or as an isolated disorder. Electrophysiologic studies are characterized by reduced resting compound muscle action potential which increases by more than 100% after high frequency stimulation. LEMS is a presynaptic disorder. The primary physiologic abnormality is a reduction of the number of packages (quanta) of acetylcholine (ACh) released by a nerve terminal. Pathogenesis of LEMS is not yet well established. An autoimmune etiology is suggested on the basis of the association with other immunologic disorders,[1-5] improvement after plasma exchange,[6] and the fact that the IgG fraction from plasma of LEMS patients when injected into mice transfers a defect of neuromuscular transmission.[7]

The prominent features of MG are extraocular and proximal limb muscle weakness, muscle fatigability, and positive edrophonium test. Repetitive nerve stimulation at slow rates produces progressive decrement in amplitude of compound muscle action potentials. The presence of acetycholine receptor antibody (AChR-ab) can be demonstrated in approximately 80-90% of MG patients. MG is a postynaptic disorder mediated by autoantibodies directed against the AChR.

We describe the patient with LEMS of nonneoplastic type associated with hypothyroidism and some features of MG. The patient demonstrates difficulties in differentiation between LEMS and MG. This case also provides further support for the autoimmune origin of LEMS.

Case report • A 59-year-old woman complained of proximal limb weakness and muscle pains since 1982. She felt deeply fatigued on awakening in the morning and remained weak throughout the entire day. She had difficulties in arising from a chair, climbing stairs, walking any longer distance than that of her own house, and raising arms above her head. Other complaints were "thick mucus" in her throat, dry mouth, and intermittent difficulty in urination. She also reported having a mild, bilateral ptosis at the onset of her illness. The initial laboratory studies disclosed that she had hypothyroidism with T4 4.9 mcg/dl (normal, 5.0-12.0) and TSH 30.4 mcIU/ml (normal, 0-7). She was treated with L-thyroxine but even during an euthyroid state her weakness was unchanged and believed to be progressive. At the end of 1983 a possibility of either polymyositis or a myasthenic syndrome was raised and patient was treated with prednisone 10 mg three times a day for six months. After initial mild improvement in muscle strength no further improvement could be obtained, and in addition she developed side effects requiring discontinuation of the drug. In October 1984 she underwent more diagnostic studies for the progressive proximal weakness. An edrophonium test was performed using a Cybex machine to quantitate muscle strength; there was over 100% improvement in strength lasting about three minutes. The test was repeated one week later in a double-blind fashion and identical improvement was noted. Serum antiskeletal muscle antibody and AChR-ab were negative. The patient was started on treatment with pyridostigmine bromide, 60 mg three times a day. A mild improvement in muscle strength was noted after the first doses but there was no further improvement even when the dose was increased to 90 mg three times a day. At this point it was believed the diagnosis of myasthenia was equivocal and the patient was referred to our institution.

Past medical history was significant for mild depression after the death of her husband in 1982. She did not smoke or drink. Family history was negative for cancer, endocrine or neuromuscular disorders.

Neurologic examination revealed presence of dry mouth, moderate weakness (3/5) of the neck extensors, deltoid and iliopsoas muscles bilaterally, absent deep tendon reflexes in the upper extremities and at the ankles, trace response at the knees, and waddling gait.

Laboratory studies showed a marked elevation in serum thyroid microsomal antibody with titer 1:1600 (normal, 0-50), and normal thyroid function (while on treatment with L-thyroxin). Electrophysiologic studies showed normal median, ulnar, peroneal and tibial nerves motor and sensory conduction velocities. The amplitude of single evoked muscle action potential was decreased. Repetitive stimulation of the right abductor pollicis brevis (APB) at the rate of 5 Hz showed 18% decremental response, while stimulation at 50 Hz caused incremental response of 400% (Fig. 1). The search for neoplasms including lung carcinoma was done but none was found. Since the electrophysiologic studies showed evidence of LEMS, pyridostigmine was stopped and the patient was started on guanidine hydrochloride (10 mg/kg body weight, increased to 20 mg/kg in three to four divided doses). One week after treatment began, the patient showed marked improvement in proximal muscle strength, being able to raise her arms above the head, arise from a chair, climb stairs, and perform daily chores, although she still complained of mild weakness. Increase of guanidine to 30 mg/kg/day did not produce any further improvement. Pyridostigmine 60 mg three times a day was added to the drug regimen. Further improvement of her strength was obtained to the point that she felt almost normal. She has been on treatment with both medications for eight months without major side effects from guanidine. No malignancy was detected during three year follow-up.

Discussion • Most clinical and electrophysiologic changes noted in our patient were characteristic of LEMS. The typical clinical features included proximal muscle weakness, descreased reflexes, muscle pains, and dry mouth (autonomic dysfunction). Electrophysiologic abnormalities were characterized by the reduced amplitude of a single evoked muscle action potential and an abnormally large increment following stimulation at 50 Hz. A favorable response to guanidine therapy was also characteristic of LEMS. The history of mild, bilateral ptosis, and twice positive edrophonium test were unusual features for LEMS and more suggestive of MG. Actually this patient was managed as having MG until a high frequency repetitive stimulation was performed. The response to edrophonium in LEMS patients is mild or absent in most cases, but occasionally positive.[8] Henriksson et al[8] reported two LEMS patients who reacted to intravenous edrophonium with dramatic clinical improvement of muscle strength lasting up to 30 minutes. The long duration of the edrophonium effect, different from that seen in MG, suggested a different mechanism of action in the two conditions. It was recommended that from a practical point of view a positive edrophonium test on muscle weakness of unclear etiology cannot be interpreted as a sign of MG.[8] The diagnostic problem is further complicated by the fact that 10% or more of the patients who do have MG fail to show antibodies to the AChR.

Our case unlike other reported LEMS cases demonstrates diagnostic difficulties because it has features of both LEMS and MG. The coexistence of LEMS and MG in our patient cannot be completely excluded. Thus, we recommend that in any patient with proximal limb weakness, positive edrophonium test and perhaps even with other features typical of

MG, but negative serum AChR-ab, a search for LEMS should be undertaken, especially if response to anticholinesterase drugs is unsatisfactory. The characteristic although nonspecific electrophysiologic feature of the syndrome is a small amplitude of the compound muscle action potential. A high frequency repetitive nerve stimulation (20-50Hz) increases the amplitude of the muscle action potentials greater than twice. Similar incremental response can be obtained by a single shock or a train of 3 per second stimuli before and after strong voluntary contraction for 10 seconds.[9]



Figs. 1A, B.—Repetitive stimulation of the right abductor pollicis brevis at the rate of 50 hz showing up to 400% incremental response.

Treatment with pyridostigmine alone in our case caused only a mild improvement; treatment with guanidine alone caused marked improvement of muscle strength, but near complete recovery could only be obtained when a combination of guanidine and pyridostigmine was used. However, guanidine should be used with caution because of its frequent and serious side effects. Other modes of treatment that have been used with beneficial effect in patients with LEMS are: 3,4 — diaminopyridine (3,4 — DAP), prednisone, azathioprine and plasma exchange.[6, 10]

The diagnosis of hypothyroidism in our patient was established on the basis of low T_4 and elevated TSH. A marked elevation of thyroid microsomal antibodies documented an autoimmune basis for hypothyroidism. The presence of associated immunologic disorders with a nonneoplastic form of LEMS was reported previously,[1-5] but the association with hypothyroidism was described only once before.[2] The latter fact supports the evidence for an autoimmune etiology of LEMS.

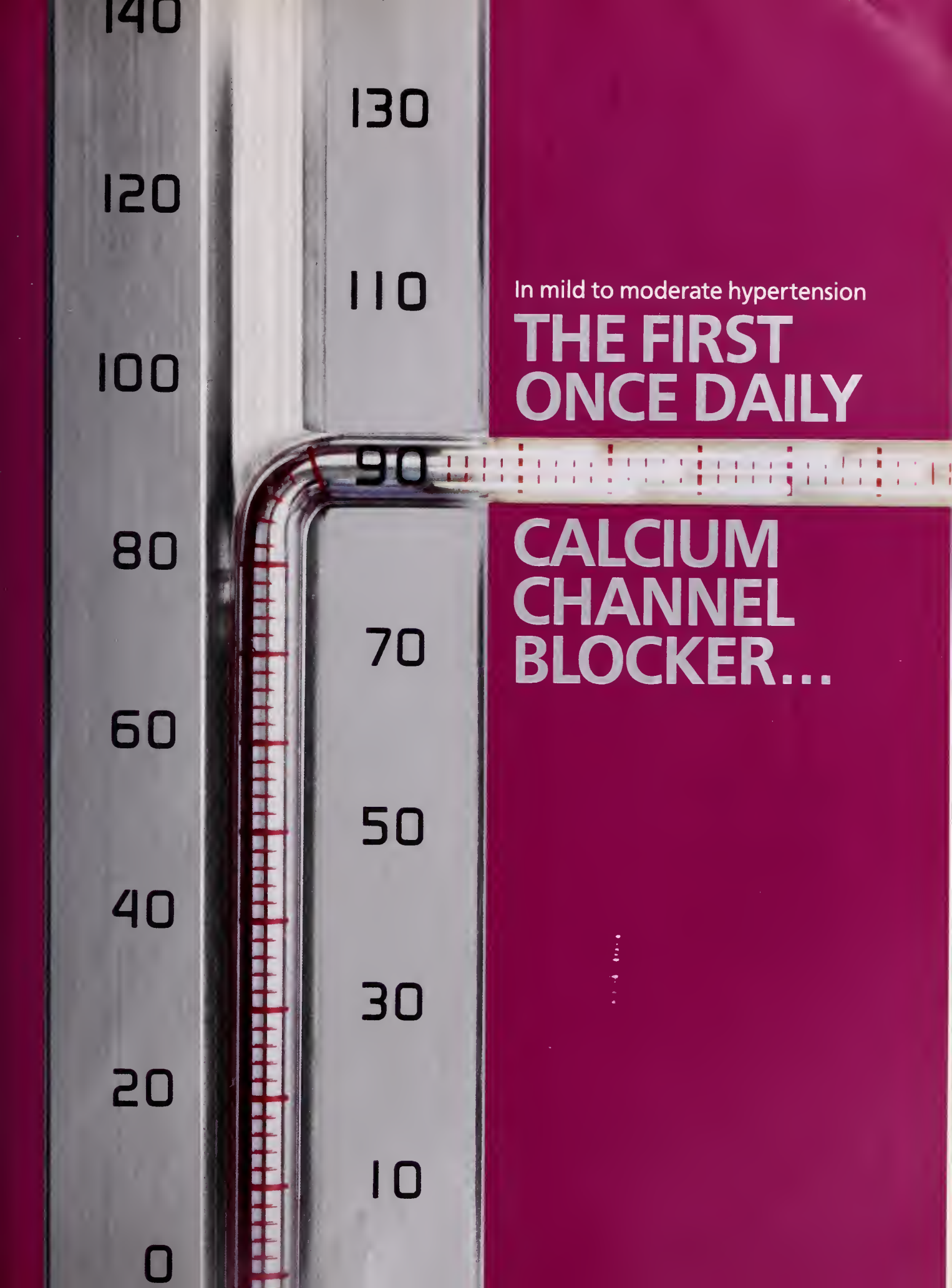
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JAMES B.
38, black male, heavy smoker. Prescribed a diuretic by another physician last year for hypertension.

YOUR CONCERNS
Presents with "smoker's cough." Workup reveals a BP of 150/107.

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ISOPTIN® (verapamil HCl/Knoll) because...
— Black hypertensives often have low plasma renin activity and generally do not respond favorably to beta blockers.
— Beta blockers may increase the likelihood of bronchospasm.

ALICE W.
65, diabetic, overweight. Her BP has elevated to 190/98.

YOUR CONCERNS
She's on daily insulin.

A LOGICAL CHOICE FOR CONTROL OF HER BP
ISOPTIN® (verapamil HCl/Knoll) because...
— Unlike most beta blockers and diuretics, ISOPTIN has no adverse effects on serum glucose levels.
— Unlike most beta blockers, ISOPTIN does not mask the symptoms of hypoglycemia.





THOMAS G.
70, asthmatic. In the past, BP adequately controlled with 25 mg hydrochlorothiazide daily.

YOUR CONCERNS
Today patient presents with symptoms of gout. Workup reveals high uric acid level, low serum potassium, and BP elevated to 180/98.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN® (verapamil HCl/Knoll) because...
— Unlike diuretics, ISOPTIN will not decrease serum potassium levels or elevate uric acid levels.
— Unlike beta blockers, ISOPTIN can be used safely in asthma and COPD patients.

JOHN K.
42, Annual physical uncovered diastolic BP of 102... confirmed on three successive office visits. Unresponsive to nonpharmacologic intervention.

YOUR CONCERNS
Salesman, spends many hours of his working day in car... total cholesterol level 300, HDL 35.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN® (verapamil HCl/Knoll) because...
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ISOPTIN® SR (verapamil HCl/Knoll) 240 mg scored, sustained-release tablets

CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: Heart Failure: ISDPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIONS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. Hypotension: ISDPTIN (verapamil HCl) may produce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. Accessory Bypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see DVERDDSAGE).

Drug Interactions: Beta Blockers: Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. Digitalis: Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISDPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. Disopyramide: Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. Quinidine: In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy. Nitrates: The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. Cimetidine: Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carbamazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may markedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in patient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISDPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. Pediatric Use: Safety and efficacy of ISDPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, edema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 3° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, dyspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, insomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, syncope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVEROOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

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Titles should be short, specific, clear and amenable to indexing.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

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SPECIAL ARTICLE

FMA turns to public for help in resolving liability crisis

Donald C. Jones

The Florida Medical Association is turning to the public once again for help in resolving the worsening liability crisis in Florida that has now become a real threat to the health and safety of the citizens of Florida.

In 1984, the public responded in overwhelming numbers to help prevent what has now become a crisis in caring. The public wrote thousands of letters to state legislators urging them to resolve the professional liability crisis. When that did not occur, they signed hundreds of thousands of petitions saying loud and clear that they wanted to have placed on the ballot for approval or disapproval by the voters a proposal that would place a limit on the amount that could be awarded for noneconomic (general) damages in liability disputes. The Florida State Supreme Court denied the public the right to vote on this important issue by removing the amendment from the ballot ruling that it violated the single subject requirement for constitutional initiatives (a ruling inconsistent with the Court's two previous actions liberally interpreting this provision) even though it had been upheld by the lower court as clearly meeting the single subject requirement. The Court had previously ignored the public's best interest when, in 1980, it struck down mediation panels which had been enacted by the Legislature as a means of curtailing frivolous lawsuits. The Court declared mediation panels unconstitutional after it had held them to be constitutional on two previous occasions. The Academy of Trial Lawyers, on the third try, had apparently convinced their colleagues in the high courts of the error of their ways in their two previous rulings. The score was now trial lawyers 2, public 0.

The Supreme Court had another chance in 1986 to act responsibly in the best interest of the public. Unfortunately, that was not to be the case. The Court, on April 24, ruled as unconstitutional a $450,000 cap on noneconomic damages in civil liability suits. The cap was part of the comprehensive Tort Reform Act enacted by the Legislature in 1986 to help resolve the state's worsening liability crisis. As FMA President Dr. James Perry said upon learning of the Court's ruling, "it is an action that is appalling and should shock the public's conscience. The Legislature had formulated a bill to address the will and best interest of all the citizens of Florida and the Supreme Court, with total disregard for the public's interest, slapped it down." At least the Court is consistent in its failings. For the third time, the Court had stricken down a law the lower court had found to be constitutionally sound. The score is now trial lawyers 3, public 0. One must wonder what voices echo in the hallowed chamber.

The Court's decision was a clear danger signal to all Floridians, health care providers, businesses of all sizes and individual citizens as to just how bad our legal system for resolving liability disputes of all types is. The ability of anyone to do business of any kind in the volatile, litigious environment that exists in Florida is in serious jeopardy. Even more critical is that the health and safety of our citizens is in great peril. Our worst fears are being realized. Health care providers (physicians and hospitals) are being forced to restrict or discontinue critical and often life saving medical services because of the liability crisis.

Despite the past failures to resolve the issue through the Legislature and the courts, the FMA will continue its efforts, but the public must demand that

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something has to be done *now* to protect their families and their own health. The FMA has launched a broad-based educational campaign to enhance the public's knowledge of the liability crisis and to seek their active support in helping to resolve it. All members of the FMA and FMA Auxiliary have received letter kits which they have been asked to distribute to their patients and other friends and business associates. The purpose of this letter kit is to encourage letters to legislators asking them to support the enactment of legislation during the current session that will place reasonable and afforable limits on the amount of damages that can be awarded in liability suits and that will serve to fairly and efficiently compensate people who have been injured through the acts of others as well as protect the rights of defendants in civil liability disputes.

The public education program also includes an outdoor billboard advertising campaign as shown on the cover of *The Journal* drawing attention to the liability crisis. The billboard campaign is being conducted during the month of May in 183 locations throughout Florida. A toll-free, 800 number is provided to call and receive information about the crisis and how the public can help. In addition, county medical societies are being encouraged to place ads in newspapers on certain targeted dates and to increase office visitation with members of their legislative delegation, both at home and in Tallahassee.

The existence of a severe professional liability crisis in the state of Florida and throughout the United States cannot be disputed through any legitimate argument or through unsubstantiated rhetoric. Tort reform legislation has been debated or enacted, or is currently under consideration by every state legislature and is actively under review by the Congress of the United States. The growing magnitude of the professional liability crisis in Florida is frightening because of the imminent threat it poses to the health and safety of our citizens as well as its adverse economic impact. There are those who attribute the crisis to insurance companies who, through either their greed for high profits or inept financial management, have fabricated the crisis. The sheer, national magnitude of this problem belies that fallacious contention. The frequency and severity of claims has continued to escalate. The number of paid claims increased from 1,812 in 1982, with an average indemnity of $82,707, to 3,250 claims in 1986, with an average indemnity of $125,942. That represents an annual increase of 12.8 percent in the total number of claims paid and a 21.3 percent increase in the size of awards. On a national basis during the 1980s, the number of malpractice claims has increased more than 300 percent between 1980-1985. Compelling evidence of the crisis is clearly documented in numerous private and governmental studies and has been attested to by notable scholars.

Is this increase in lawsuits and awards due to bad doctors? Doctors today are better educated and trained than ever before, backed up by medical technology which has advanced further in the past ten years than any other period in medical history. Virtually all of Florida's approximately 150 neurosurgeons have been sued one or more times. Can all of these highly skilled surgeons be "bad" doctors? Of course not!

There is a real threat to the ability of physicians to continue to provide vital and often life saving health care services. In many cases, these have already been discontinued or severely limited. Thirty percent of the state's obstetricians and gynecologists have quit delivering babies. The obstetricians in Palm Beach County have advised their patients that they may no longer be able to deliver babies after July 1. All five neurosurgeons on the staff of St. Mary's Hospital in Palm Beach County have resigned as have the approximately 16 orthopedic surgeons from the staff of Good Samaritan Hospital in that county. In January of this year, 17 of the 26 hospitals in Dade County were forced to discontinue or severely restrict emergency room and trauma services because of the fear of liability. There is but one neurosurgeon providing care for all of North and Central Brevard County. In Duval County, the majority of neurosurgeons have notified hospitals that they will no longer take emergency room calls after July 1 and the city's hospital has indicated a reduction in emergency room care after June 1. The list of examples could go on and on.

Further evidence of the worsening crisis was the announcement last week by two of the state's largest liability insurers that they were withdrawing from the Florida market. CIGNA Insurance Company, which insures approximately 2,500 physicians in Florida, announced that it was withdrawing from the liability insurance market in every state. St. Paul Insurance Company, which insures approximately 5,500 physicians and surgeons in Florida, has notified its subscribers that policies will not be renewed after July 1 because of that company's failure to win approval from the State Insurance Department for a 30 percent increase in premiums that St. Paul says is necessary in order to remain in the Florida market.

The market availability problem created by this action prompted Insurance Commissioner Bill Gunter to propose establishment of a mandatory, state operated insurance pool in which all physicians and hospitals in Florida would be required to participate. On April 24, the FMA issued a statement in response to Insurance Commissioner Gunter's proposal. The Commissioner is to be commended for his forthright acknowledgment of the magnitude of the crisis in our state. His testimony before the House Insurance Committee substantiates the fact that the liability crisis threatens the health and safety of the citizens of Florida and is not a myth fabricated out of physicians' economic self-interest. His proposal, however, for a mandatory insurance pool to resolve this problem is

totally unacceptable. The solution of this problem cannot be imposed on the backs of the public through continually increased health care costs. Also, his proposal would only impose further penalties and hardships on the state's hospitals and physicians. It is a futile effort that, in reality, would only sweep what has become a massive societal problem under the rug. It does nothing to address the root of the problem which is a totally, inefficient and inequitable tort system that has been abused sorely and unfairly. This has been to the detriment of those who have been injured in the course of health care delivery as well as to the defendants in medical malpractice suits. This abuse has caused the current crisis.

The FMA feels that the liability crisis is a matter of most important and critical urgency and that our tort system has become incapable of serving as an equitable and efficient arbiter for the solution of civil liability disputes. The FMA feels that the time has come for all of us, the medical profession, the legal profession, the Legislature, business and industry representatives of the public, to come together to face this issue head on and to resolve it once and for all before it further devastates the health and safety of our citizens as well as our economic stability.

The FMA also feels that the time has come for the Academy of Florida Trial Lawyers to be called to account by the media, the Legislature and the public for the responsibilities that a small segment of its membership bears for the finanical exploitation of the tort system and the perpetuation of this crisis. All over this country we have witnessed a concerted action by the Academy of American Trial Lawyers and its state components to undermine virtually every attempt to reform this country's inept tort system. The legitimacy of claims of some personal injury attorneys that they are committed to serving and protecting the public's rights should be carefully scrutinized in light of the tremendous financial rewards that have been garnered from this system and should be measured as well against the renumeration paid to the injured parties they purport to represent.

The FMA Board of Governors met jointly in Tallahassee on Wednesday, May 13, with officers, executive directors and other representatives of county medical societies, FMA recognized specialty groups and FMA Auxiliary leaders to discuss the Association's continuing efforts to resolve the crisis.

The Board received a report and recommendations from the FMA Council of County Medical Society Officers that met earlier to receive input from officers representing 22 component county medical societies. Dr. Bruce Weissman, Chairman of the Council, presented the recommendations to the Board as unanimously adopted by the Council. Based on the recommendations of the Council representatives attending the meeting, the Board took the following action:

Reaffirmed FMA endorsement of the "Barron Plan" for resolving medical professional liability claims, and called on the Legislature to enact the Plan during the current legislative session. If unable to grant this urgent request before the 60-day session is scheduled to end on June 5, a special session should be held for this purpose. The Barron Plan was originated by the Senior member of the Legislature, State Senator Dempsey Barron, D-Panama City. The Plan, which has similarities to the State's Workers' Compensation Act, contains a threshold for recovery of damages and *negligence* would have to be proven to recover any medical malpractice damages. *It is not a no-fault program.* A brief summary of the provisions of the Barron Plan includes:

- The approach embodies certain elements of the workers' compensation law.
- It transforms the basis for the resolution of malpractice suits from tort law to contract law.
- It utilizes a scheduled benefit compensation system such as is utilized for workers' compensation.
- It eliminates jury trials and adjudicates claims before a judge. Most cases would be resolved by the insurance carrier and very few cases would be brought before a judge.
- Provider participation in the system would be mandatory. Each provider would be required, as a condition of licensure, to purchase medical incident insurance or be self-insured, as is now the law in Florida.
- In the event of a compensable injury, the mandated insurance would be the primary source of coverage for compensation.
- Claims for lost wages, rehabilitation and benefits for dependents would be unlimited in amount. Lost wages and benefits for dependents would be paid out periodically rather than in a lump sum.
- Damages for permanent disabilities or death would be limited to $100,000.
- The court would set reasonable attorney fees thus eliminating the contingency fee.
- The system would be self-executing in that types of losses would be defined and claims for same would be filed and handled by the provider, the carrier or an independent administrative agency.

The Board reaffirmed its plans adopted in late February to continue to develop a constitutional amendment petition program to place a cap on noneconomic damages in the amount of $100,000.

The Board approved an FMA policy statement regarding the availability of insurance for physicians:

THE FMA IS SYMPATHETIC TO THE PROBLEM BEING FACED BY THOSE FLORIDA PHYSICIANS WHOSE INSURANCE COVERAGE MAY LAPSE ON JULY 1 DUE TO THE ANTICIPATED

WITHDRAWAL FROM THE INSURANCE MARKET BY AT LEAST TWO MAJOR MEDICAL MALPRACTICE INSURANCE COMPANIES IN FLORIDA. THE FMA WILL CONTINUE WORKING AGGRESSIVELY TO ASSURE THE AVAILABILITY OF INSURANCE FOR THESE PHYSICIANS THAT WILL PROVIDE ADEQUATE COVERAGE AT THE MOST REASONABLE COST. UNTIL SUCH TIME AS SUCH INSURANCE CAN BE MADE AVAILABLE, THE FMA RECOMMENDS THAT PHYSICIANS USE EVERY CAUTION TO REFRAIN FROM PRACTICING MEDICINE IN ANY MANNER WHICH PUTS THEM IN VIOLATION OF CURRENT FLORIDA STATUTES. THE FMA IS OPPOSED TO ANY PLAN THAT CALLS FOR A MANDATORY STATE OPERATED INSURANCE POOL OR WHICH CALLS FOR A SUBSIDY OF INSURANCE PREMIUMS.

The Board referred to FLAMPAC for study and action the recommendation that physicians and local medical PACs become actively involved in the election and/or retention of judges. Circuit and county court judges are elected by the people. On the appellate and supreme court level, judges are appointed. But every six years, their names must be placed on the ballot for retention or rejection by the voters of Florida.

A proposed resolution was referred to the FMA Council on Legislation to evaluate the feasibility of legislation that would prohibit St. Paul and other insurance carriers from writing other casualty insurance without offering medical malpractice coverage at a balanced rate based on profits from other lines.

The Board reaffirmed the FMA's strong opposition to any legislative proposals similar to the Cleveland Clinic plan to locate in Broward County that would allow physicians to become licensed in Florida without having to follow the same prescribed procedures and examinations as other physicians who practice in the state as required by Florida law.

The Board approved the recommendation that FMA actively oppose the use of diagnostic guidelines drafted by Blue Cross/Blue Shield that would prohibit diagnostic testing by doctors the company deems unnecessary but that physicians regard as appropriate and, in many cases, essential for defensive medicine.

FMA President Dr. Perry expressed the Association's appreciation to approximately 150 county medical society, specialty group and Auxiliary representatives who attended the meeting and for their active participation in the discussions. He said the input of the Council of CMS Officers representing the grassroots members was greatly beneficial to the Board of Governors. He reiterated the critical need for a total unified effort through FMA if the medical profession is to be successful in resolving the professional liability crisis.

The Board also considered recommendations from the FMA Council on Legislation and took the following actions:

1. The Board authorized an investigation of the feasibility of a class action suit against the CIGNA Insurance Company and St. Paul Fire & Casualty Company regarding the actual or potential withdrawal of insurance coverage for physicians in Florida.
2. The Board approved the recommendation that the FMA urge the St. Paul Insurance Company to continue to provide professional liability insurance coverage for physicians in Florida at affordable rate.

Following the meeting, members of the Board of Governors, along with Dr. Peter Tomasello, President of the Broward County Medical Association, representing the Council of County Medical Society Officers, met separately with House Speaker Jon Mills, D-Gainesville, and Senate President John Vogt, D-Cocoa Beach. The Speaker and President offered cooperation in granting members of the Legislature an opportunity to analyze and consider resolutions to the liability crisis including the Barron proposal. Attending the session with Senator Vogt were Senators Dempsey Barron; Tony Jennings, R-Orlando; and Mattox Hair, D-Jacksonville. Senator Barron indicated to the Board that he would give his full commitment to the enactment of his proposal during the 1988 session. The FMA is working to identify our strongest legislative support in the House.

It is crucial that physicians begin contacting representatives and senators *now* urging their support for the Barron Plan and that they call on the House and Senate leadership to support the expedient approval of the proposal.

The FMA has pledged to the Governor, the Legislature and to the public, whose interests we should all be serving, to work cooperatively to resolve the liability crisis in our state once and for all. But resolve it we must!

● Mr. Jones, FMA Headquarters, P.O. Box 2411, Jacksonville 32204.

On the Aesculapion at Pergamum; Pergamum paper; Galen and the Caduceus

Manuel Viamonte Jr., M.D., and Maria Viamonte, M.D.

Aesculapius (Asklepios; Lat. Aesculapius) was the Greek god of healing, the son of the sun god, Apollo, and the nymph, Coronis. Homer's *Iliad* mentions him only as a skillful physician. He was honored as a hero and worshipped as a god. Aesculapius is frequently represented in ancient sculptures and on coins as a handsome, Jove-like figure, standing, dressed in a long cloak, with bare breast. His usual attribute is a club-like staff with a serpent coiled around it, which according to the *Encyclopaedia Britannica* is the only true symbol of medicine.

Temples in honor of Aesculapius were erected in many parts of Greece, near mineral springs or on high mountains. Aesculapions or health centers were named after the god, Aesculapius, and originated about the 6th century B.C. The doctors practicing in these health centers were referred to as Aesculapiads (Asclepiads). There were Aesculapions in several areas of Greece and Turkey, for example, Cos, Cnidus, Epidaurus, and Pergamus.

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The city of Bergama (the ancient city of Pergamum) is located in Turkey, 100 kilometers north of Dikili, and 45 kilometers west of Soma. Pergamum was the capital of Mysia in Asia Minor. In 1986 it had a population of 30,000 people. Between the years 1900 and 1923, many excavations were made at the site of this ancient health center.

The Pergamum "Health Center" (Fig. 1) was built around the 4th century B.C. by the son of Aristacminos, Archais. Written boldly above the entrance of the Aesculapion at Pergamum were the words, "By the order of the gods, here death does not roam." This internationally famous health center seems to have followed a triage system whereby patients, who arrived at the hospital, considered to be too ill, were rejected. It was considered prudent and moral to refuse to treat the hopeless. On the other hand, those who were admitted apparently left alive although not always cured. If a person were able to walk the one kilometer distance of the Holy Road from Pergamum to the hospital, they were considered in reasonable health and, having passed this test, became a candidate for admission. For several hundred years it was claimed that no patient died at the Aesculapion of Pergamum.

The health center had a large amphitheater with a 3,500 seating capacity. There were 16 seats for "VIPs". In front of the seats was a half-circular area for the orchestra and in front of it the proscenium or front stage designed in such a way as to best facilitate the acoustics. Music and other expressions of art were considered essential in the treatment of patients. There was a circle of corridors with an open structure for sports events. Walking and running were also

believed to be good for the preservation and recovery of health.

Of interest is the very large library, measuring 16.5 × 18.5 meters. (Fig. 2) No other Aesculapion had such a library. Its construction was unique in that it was surrounded by two walls separated by a layer of air. This mode of construction helped regulate the temperature and humidity, vital for a library.

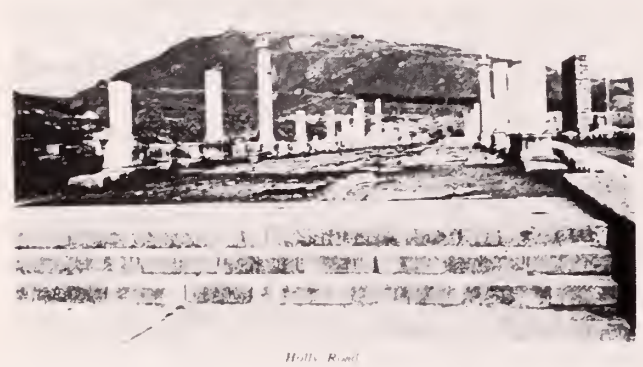


Fig. 1.—The Pergamum "Health Center."



Fig. 2.—The large library of the Aesculapion of Pergamum. No other Aesculapion had such a library.

Pergamena (Pergamum paper) • The library of Pergamum is claimed to have had more than 200,000 literary works. History tells us, however, that it was lost when Marcus Antonius presented this treasure to the Queen of Egypt, Cleopatra.

There were mineral waters and pools in the large ceremonial grounds located in the northeast sector of the complex. The water was considered to have curative properties, particularly for mentally disturbed individuals. It would have been interesting to have analyzed the lithium content of this water.

The holy basement of Kriptoportikos lead to the Temple of Telesphoros which had a waiting lounge for patients. Religious beliefs were also considered an important element for the cure of individuals.

The Circular Cure Center, two stories tall, had a top floor which was circular with six adjoining rooms. The practice of sleeping in these centers appeared to have been very common, it being supposed that the god effected cures or prescribed remedies to the sick during their dreams. The most important structure, where cures took place during the worshiper's dreams was the "abaton", the incubation site. Some patients apparently received some sort of tranquilizer here and were told that the god of health would inform them in their dreams which medicine would cure their ailments. Upon awakening, the patient would whisper the medicine's name through small apertures to waiting doctors, in a somewhat similar manner to confessionals in the Roman Catholic church.

There was a long corridor that joined the building where there were drawings which ranged from childhood scenes to representative pictures typical of encounters one might have during adult life. Patients were asked to walk through and pause in front of the drawing that made the greatest impression. This was possibly used by the doctors to establish the time in the life of the patient when events occurred that might have led to the patient's illness.

Perhaps the reasoning behind the claim of no death was the carefully selected patients, coupled with the excellent management of those who were admitted. After ritual bathing, patients were dressed in white robes and encouraged to forget their illnesses. Treatment consisted primarily of faith, mineral waters, abstinence from specific foods and wine or even fasting, herbs, mud baths, exercise, music, meditation, rituals, relaxation, rest, drugs to induce somnolence, sleep, entertainment, reading, dialogue (psychotherapy), laying on of hands, and applying medications.

Wounds were mended with holy wine; pneumonias with rags saturated with wine and then placed over the lung; ulcer patients were treated with milk, olive oil, butter, and honey. Hemoptysis was dealt with by smashing seed of pine in honey; headaches with herbs and olive oil; tonsillitis by gargling with cold water. But perhaps the most important ingredient in the effectiveness of the temple's

cure was the inspiring of a religious and spiritual atmosphere.

Comparing the methods used for the management of psychosomatic disorders to those employed today (about 2,000 years later), very little has changed in the basic medical approach.

During this period all manuscripts were written on papyrus which could only be made from a sedge grass, Cyprus papyrus, that grew on the shores of the Nile River in Egypt. When the library of Pergamum achieved a high status and reputedly outshone Alexandria's in Egypt, King Epiphames placed an embargo on the export of papyrus. King Eumenes of Pergamum counteracted by offering a reward for a suitable substitute. The Smyrniots responded by bringing a substitute made from goat's skin. Cleaned, scraped skin was placed into liquid lime, then tightly pasted on wood and allowed to dry. The new product (parchment) was called Pergamena (Pergamum paper).

Galen and the Caduceus • Galen, the most famous Greek physician was born in Pergamum in 131 A.D., and practiced at this health center. He died approximately in the year 201 A.D. He became a physician at the age of 21 and by the age of 28 was mending the wounds of gladiators. At age 32 he cured Marcus Aurelius. Galen was the founder of experimental physiology and, after Hippocrates, the most distinguished physician of antiquity. He authored about 400 treatises which were written in clear Attic Greek. Galen's anatomical investigations were unrivaled for their fullness and accuracy. He was an indefatigable dissector, describing mainly what he actually saw. He dissected apes and lower animals, though much that is relevant to the human body is incorporated in his works. He recognized the lacteal vessels; described the ducts of the lingual and submaxillary glands though he was unaware of their function; described the mode of closure of the foramen ovale; performed revolutionary physiological investigations; performed dissection of the spinal cord at various levels and observed the resulting sensory and motor disturbances and incontinence; described accurately the valves of the heart; described aneurysms, differentiating the traumatic from the dilated variety; described the hand with exquisite detail; was familiar with the use of the catheter; and was a firm believer in the supreme Creator of the Universe in all its parts. He set himself to prove that the bodily organs are in such perfect relation to the functions to which they minister that it would not be possible to imagine any better arrangement. In addition to being monotheistic, he claimed that God's purpose could be elicited in great detail from the examination of his works. He accepted the divine guide and architect of the universe which corresponded to the Christian scheme, but rejected all ideas of miracles.

There are many legends concerning Galen. One is that at the time of his death, he asked his assistants to place one medicine in a clay pot and another in a water-filled jug. Whereupon, the pot melted and the water froze. Galen then remarked, " I have found the cure for everything, but not the medicine for death."



Fig. 3.—The Caduceus monument that still stands at the entrance of the Aesculapion of Pergamum.

The caduceus (cuduceum) (Fig. 3) in classical terms was a badge designating the bearer as a sacred person not to be molested. Originally it may very well have been of magical potency, supposed to protect its bearer as various other sticks or staves, e.g., a king's sceptre, were thought to have been. Caduceus is a Latin loan word, its etiology Greek karykeion from kryx ("herald"), hence "herald's badge of office". Its original form was, in all probability, a straight branch from the top of which two twigs grew, something like a dowser's rod. These twigs were interpreted as snakes and, thus, the caduceus is often shown with two snakes entwined, somewhat like the staff carried by Aesculapius. The most characteristic bearer of the caduceus was Hermes who, as described by Homer and later writers, ran errands for the greater gods, especially Zeus and so was easily thought of as the herald and patron of all heralds and other wayfarers. Karykeion is not to be confused with the magic wand which Hermes and, on occasion, other gods sometimes carried

The Caduceus with its winged staff and interwined snakes, frequently used in the USA as a medical emblem, is without medical revelance according to the *Encyclopaedia Brittanica* since it represents the magic wand of Hermes or Mercury.

There is also the legend of the very sick man who, while on his journey back to Pergamum after being rejected by the hospital, saw two snakes spitting their poison into a milk cup. Being both sad and discouraged, he attempted suicide by drinking its content. He survived. On this Galen commented, "I have assumed that the injection of poison at times could cause recovery, but was afraid to test it on human beings." Thus, there is another legendary origin of the symbol of Aesculapion, the caduceus. A first caduceus monument still stands at the entrance off the Aesculapion of Pergamum (Fig. 3).

In summary, this small community was truly remarkable, having had the most famous hospital of antiquity and one of the most famous libraries of all times, as well as originating the first manuscripts written on parchment, and being the birthplace of one of the symbols of medicine, the caduceus.

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An epitaph for Medicare

The behemoth that is government shares some behavioral quirks with several giants who have played the pages of literature. Euripides characterized Hercules as an individual capable of physically stupendous feats but one who was handicapped by a feeble intellect. His strength unwittingly brought about the deaths of a favorite servant as well as his wife and children. In *Of Mice and Men* Steinbeck presents the huge half-wit, Lenny Small, as a muscularly vigorous but mentally ingenuous soul with an unfortunate knack for permanently quenching the respiratory efforts of human and lesser creatures who dallied too close for too long. Government is tragically plagued with similar traits. As it exerts its regulatory might it frequently destroys the individuals or programs it is attempting to aid. An example is the recent physician fee freeze and the continued, severe restriction of future physician fee increases. The severe bridling of physicians' fees promulgated in the current Medicare rules has the potential for not only despoiling the income of physicians but also for scuttling the entire Medicare system itself.

The Medicare regulations that have frozen physician fees for the past three years and have been reformulated to permit a meager 1% increase in our fees for the next three years threaten the economic demise of private practitioners. The mathematical consequences of such financial stringency either have not been appreciated by the leaders of organized medicine, or have not been addressed by them. The difficulty with this reimbursement formula is that we are reentering a period of inflationary economic conditions in the United States. An average estimate of the inflation rate for 1987 is about 5%, and higher estimates are projected for the next one or two years. The costs of overhead for medical practitioners will increase at least as rapidly as the national inflation rate. Therefore, there should be a minimal differential of four percentage points between the increments in allowed charges for physician services and the actual costs of providing those services (assuming, quite conservatively, an average inflation rate of 5% for the next few years, and the 1% rate increase permitted by Medicare.) Primary care doctors, who have larger overheads than surgical specialists because of the intensity of the personnel input into patient care, will be particularly squeezed because they will not be able to raise their charges to meet their costs.

Table 1 illustrates the effect of time and the 4% inflation-charge differential on Medicare income. The data were generated by an iterative computer program, with the following assumptions: (1) Current overhead for care of 50%, i.e., for every $1,000 generated in gross Medicare collections, $500 will be spent for overhead and $500 will accrue to the doctor as the before-tax, net income. (2) The 4% differential between annual reimbursement increment and inflation rate will persist into the indefinite future. (3) The doctor's net income has been adjusted for inflation and expressed in 1987 dollars to generate a more meaningful evaluation of the dollar amounts projected and a more realistic appreciation of the 4% reimbursement rate-inflation rate gap.

The results reveal the following discomfiting observations. First, in five years the overhead cost of caring for a Medicare patient will have increased to 60%; in ten years to 73%; and in 15 years to 89% of the total fees generated. In 18 years the care of each patient will produce a loss to each physician. More disquieting though is the effect on before-tax, inflation-adjusted income. The table depicts the effect of the uncompensated increase in overhead plus the effect of inflation on every thousand dollars of gross Medicare income that is generated when expressed in 1987 dollars. The effort and time necessary to provide $500 of net income in 1987 will result in $323 of 1987 dollars in five years, in $178 in ten years, and in only $58 in 15 years.

Roughly the same figures will be generated if the inflation rate increases above 5% and the government increases its reimbursement to a level that will sustain the inflation rate-reimbursement rate gap at 4%. The figures become more ominous if the gap widens. Obviously, care of a significant number of Medicare

Table 1—Effect of 5% cost inflation and 1% fee inflation on future physician net income.

Year	Gross[1] Income	Overhead[1] Cost	Net[1] Income	Inflation-Adjusted[2] Net Income
0	1000	500	500	500
5	1051	638	412	323
10	1104	814	296	178
15	1160	1039	121	58
20	1220	1326	−106	−40

[1]*Expressed in inflation-unadjusted dollars.*
[2]*Expressed in inflation-adjusted, i.e., constant 1987.*

patients under these conditions will lead to economic rapine.

A physician's initial response to these projections is to attempt to shift the increased costs of caring for the Medicare patient to other patients. This has been done repeatedly during the last decade as government and Blue Cross/Blue Shield have reduced reimbursements. However, this practice is becoming less acceptable to the insurance companies and employers to whom this burden is shifted.

Table 2 expresses the results of calculating the magnitude of the fee that would have to be imposed on non-Medicare patients to allow physicians to maintain their present income, expressed in constant, inflation-adjusted dollars. The computer program assumed the same conditions as those introduced for Table 1: Medicare reimbursement increases trail inflation rate increases by 4%, and the doctor sees the same number of total patients per year. Overhead is intially 50% of gross income. Additionally, a realistic 20% fee differential between Medicare and non-Medicare patients was assumed to be in effect at baseline; e.g., for an intermediate office visit, code #90060, the Medicare fee was set at $25 and the non-Medicare fee at $30. The table portrays that, in ten years, the non-Medicare fee for the 90060 procedure would have to be $50 in the physician practice in which Medicare patients comprised 10% of the patient population, but $55, $64, and $85 for the practice that had 30%, 50%, 70% Medicare patients. The allowable Medicare charge would only be $28.31. Therefore, the percentage differentials between Medicare and non-Medicare fees would have to be 100% to 300% greater in 1997 for the non-Medicare patient if physicians were to maintain their current standard of living at that time. This wide disparity between Medicare and non-Medicare fees is unacceptable. Thus cost-shifting is not a realistic alternative to the government enforced limitation on fees.

A more realistic projection is that doctors will raise their fees to non-Medicare patients at a rate indexed to the inflation rate. However, a doctor glut is developing and, in 1995, Florida will have 15% to 20% more physicians than is required. One can examine a third scenario by computer. In this example, we will assume that, in 1987, the average doctor earns $100,000 before taxes, that his gross practice income is $200,000 and that his overhead percentage is currently 50%. We will also assume that Medicare perpetuates its limitation on physician fees and the 4% hiatus between the actual inflation rate and the permissible Medicare rate of fee increase. We will conservatively estimate that the number of patients seen by the doctor decreases by 1% per year because of the increased supply of physicians. Finally, all calculations of net income will be expressed in constant 1987 dollars.

Table 2.—Cost shifting analysis. Effect of 5% cost inflation and 1% fee inflation on physician income. Fees that would have to be charged to non-Medicare patients for an intermediate office visit (code #90060) to maintain 1987 net income constant. Assume constant patient volume and a baseline fee of $25 for Medicare patients and $30 for non-Medicare patients.

Year	Future Fee Proportion of Practice Dedicated to Medicare Patients			
	10%	30%	50%	70%
0	30	30	30	30
5	39	41	45	54
10	50	55	64	85
15	65	74	89	126
20	84	98	122	170

Table 3 shows the results of the analysis. The physician who limits the Medicare population to

Table 3.—Effect of 4% gap between cost inflation and fee inflation upon physician net income. Effect of time and the proportion of Medicare population with the physician in practice. Results are expressed in inflation-adjusted 1987 dollars. Assumptions are that the physician had a 1987 gross income of $200,000 and a net, before-tax of $100,000, and that the practice patient population would recede at a rate of 1% per year. It is also assumed that fees to non-Medicare patients will increase commensurate with inflation rate.

Year	Future Net Income[1] Proportion of Practice Dedicated to Medicare Patients			
	10%	30%	50%	70%
0	100,000	100,000	100,000	100,000
5	86,934	80,216	73,499	66,781
10	75,230	63,575	51,920	40,265
15	64,663	49,450	34,236	19,023
20	55,056	37,349	19,643	1,937

[1]*Expressed in constant, 1987 dollars.*

10% of the practice volume will net $87,000 in five years, $75,000 in ten years and $55,000 in 20 years. If Medicare patients compose 30% of the practice the earnings are $80,000, $64,000 and $37,000 in five, ten and 20 years; for a practice consisting of 50% Medicare patients the figures are $73,000, $52,000 and $20,000 in five, ten and 20 years; and for the practice with 70% Medicare the numbers are $67,000, $40,000 and $2,000 respectively. The practitioner who continues to serve a large number of Medicare patients under the current regulatory conditions commits himself or herself to economic penury. Of course, physicians who grant 20% discounts in their fees to HMOs and PPOs will likewise accelerate their economic interment.

The economic eclipse for physicians . . . may be welcomed by those in power who deem physicians overpaid for their training, 60-hour work weeks and the six-figure cost and indebtedness incurred during their training. However, the gloom will enshroud the Medicare patient population itself and, contrary to common wisdom, will strangle, rather than revivify, the health-care system for the elderly.

The economic eclipse for physicians that these projections forecast may be welcomed by those in power who deem physicians overpaid for their training, 60-hour work weeks and the six-figure cost and indebtedness incurred during their training. However, the gloom will enshroud the Medicare patient population itself, and contrary to common wisdom, will strangle, rather than revivify, the health-care system for the elderly.

Economic history is replete with precedents of the adverse effects of price fixing on the goals of government. Almost always the results of severe price restraint results in so much economic disruption that the long-term cost of the restrictive policies exceeds the savings of the policy. The same effect will be observed in the Medicare program. How will this occur?

One of the goals of the medical regulators is to transfer care of the elderly patient away from the specialists and into the practices of primary physicians. Allegedly the cost of care given by primary care doctors is cheaper. This has never been borne out by any study but rather is theoretical. Let us momentarily accept, a priori, the premise that primary care doctors can provide cheaper care for the elderly than specialists. Will the primary care doctors be able to afford to care for an elderly patient under these stifling reimbursement policies? They will not be able to afford to do so. Primary care medicine is difficult to discharge more efficiently because it consumes more personal input per unit of doctor income than any other outpatient specialty. Moreover the elderly patients are pathologically complex. They often have a multitude of illnesses, each of which demands a variable amount of care. Often these illnesses are chronic and difficult to treat. Furthermore the medications frequently are metabolized differently by the geriatric patients and may not be as well tolerated by them. This makes their care even more difficult. Today, the primary care doctor may attend to several of the illnesses afflicting an elderly person during a single visit; the severity of the economic projections discussed previously will make this practice unaffordable in the future. The primary care doctor will, like his colleagues in Great Britain, transfer care of the more time consumptive problems to a variety of specialists and focus on the simple, rapidly treatable problems. Thus, specialist utilization will increase rather than diminish. The only foreseeable means to avoid this situation is to enhance reimbursement of the primary care physician to a level commensurate with other members of society who accept the same amount of duress and responsibility. This requirement is discordant with the medical reimbursement trends in U.S. medicine that have been in place during the past 30 years.

The reader who interprets this perspective as a surrealistic chimera need only travel to Great Britain and spend a few days in the offices of a few urban, general practitioners who practice solely in the National Health Service. This experience will trans-

Financial constraints will coerce the American physician to limit the quality and quantity of service to Medicare patients . . . However, the culture of the American people will not tolerate such treatment.

migrate one across the borders of geography and time into a Dickensian scene of an office furnished sparsely with mildewed drapes and time-worn rugs enclosed by somber chipped walls of faded tans and grays. Patients quietly file into the dimly lit darkness, sit quickly and rapidly expound on their chief complaint. A few words from the physician follow, a rapidly penned prescription is proffered and the patient leaves, to be instantly replaced by the next-in-line. The retinue thus proceeds for a few hours; the pace is rarely punctuated by a patient examination or an in-depth history. A patient who appears seriously ill may receive a cursory glance at the major organ system involved but then is quickly dispatched to a hospital or specialist suite for further care. Intellectual or patient conveniences such as office laboratories or EKGs are rarely seen. The primary care doctor, in this setting, has been depreciated to a triage agent rather than sustaining the role as a scientifically informed physician. The situational economics prevent him from functioning otherwise.

Government minions will try to shift the blame for the devastation of the Medicare system to "greedy doctors" . . . It is not the greed of doctors that will ruin the Medicare system. It is the Lenny Small mentality of regulators who are incapable of foreseeing the devastation that will be wrought by their shallowly contemplated policies.

Financial constraints will coerce the American physician to limit the quality and quantity of service to Medicare patients in the same fashion. However, the culture of the American people will not tolerate such treatment. Wealthier patients will particularly resent such curtailment of their access to quality medical care and will either opt out for the Medicare system or force the legislators to allow them to purchase the quality of care they can afford. Physicians will obviously adapt their practices to the patient who is willing to pay a reasonable fee for services and avoid those patients who cannot or are unwilling to pay for such services. One need look no further than at the current Florida Medicaid program to determine consequences of an absurd fee schedule on the availability of health care. Thus, a two-tiered system of medical care will be established for the elderly population in the same manner that it has been established for the rest of the American population. The Medicare program wil have evolved in a completed circular path: the intent of the draftsmen of the original Medicare legislation was to assure access to quality care for the entire elderly population—to homogenize rather than to fractionate access to care. In ten to 15 years access will be severely limited to a huge percentage of the elderly and large caste of elderly, medically indigent will be heaped upon the current large mass of medically indigent folk.

Government minions will try to shift the blame for the devastation of the Medicare system to "greedy doctors." Physicians' fees have been censured as a major cause of the escalation in health care costs, and an average, before tax income of $108,000 a year (1986) has been cited as excessive. Physicians need to confront these charges and not be apologetic about their incomes.

Are doctors incomes really excessive? Not when compared to the salaries of other professionals in the United States. The average starting salaries for law school graduates who entered Wall Street firms last year exceeded $85,000. The average, major league player's salary for the 1987 season is more than $250,000. Most managers in the upper-middle echelons of the corporate structure earn $80,000 to $100,000 per year. Furthermore, the average salary for primary care doctors is considerably less than $108,000; in 1985 it was about $85,000. Primary care doctors have actually experienced a 35% decline in their inflation adjusted income during the past decade as their fee increases have been unable to match the increasing costs of providing patient care. It is not the greed of doctors that will ruin the Medicare system. It is the Lenny Small mentality of regulators who are incapable of foreseeing the devastation that will be wrought by their shallowly contemplated policies.

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Skin and skin structure infections caused by staphylococci and/or streptococci

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Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli, P mirabilis,* and *Klebsiella* sp.

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

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Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile.* Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

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Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

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Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose, the drug reached a maximum level of 4 μg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

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☐ NOTES & NEWS

Searle "Alliance for Health Care" to explore solutions to medical malpractice crisis

G.D. Searle & Co. has announced it is establishing the Searle Alliance for Health Care, an organization chartered to explore and seek solutions to the national dilemma of the physicians' malpractice crisis.

Throughout the year, the Searle Alliance, working with physicians, policymakers and other experts in health care, will examine the entire issue of professional liability as it pertains to law, insurance, government, public policy and medicine. The Alliance will sponsor programs in medical and consumer education, and encourage a public discussion of the problem.

One medical specialty particularly hard hit by the situation in professional liability is obstetrics. One in eight obstetricians has stopped delivering babies and 23 percent have eliminated or reduced the number of their high-risk obstetrical cases because of soaring malpractice insurance costs. Obsetetrician/gynecologists pay up to four times more for malpractice insurance than other medical specialties.

The trend is leaving fewer physicians to deliver babies, and dramatically raising the cost of obstetrical care, according to Kenneth Heland, Associate Director, Department of Professional Liability of the American College of Obstetricians and Gynecologists (ACOG).

"Obstetricians/gynecologists beginning a career today can expect to face malpractice suits an average of eight times in their careers," according to Heland. "OB/GYNs have a one in four chance of being sued for malpractice within any given year. Malpractice concerns have caused one-fourth of OB/GYNs in Florida to stop practicing. In Maryland, malpractice premiums for OB/GYNs have risen 200 percent in the past two years."

"The national impact of this crisis is much more far-reaching than many realize," said Kenneth J. Ryan, M.D., Chairman of the Department of Obstetrics and Gynecology at the Harvard Medical School. "The early loss of experienced practitioners has not only reduced the availability of care for patients, but it has limited the number of experienced physicians who are able to devote part of their time to teaching. The cost of malpractice is becoming so high, that practicing physicians cannot afford to take days out of their practice to teach. Even though practicing physicians make some of our best teachers, these doctors are forced to see more patients just to pay for the cost of their malpractice premiums.

"The malpractice situation has unfortunately placed physicians and patients in an adversarial role," Dr. Ryan said, "undermining the doctor/patient relationship."

"Natural childbirth is no longer a trend or just a patient preference, it has become the standard of practice wherever possible," Dr. Ryan continued. "However, because of the increased risks associated with this method of delivery, the malpractice situation is fast eliminating this as a patient option."

In announcing the formation of the Searle Alliance for Health Care, David R. Bethune, President of Searle's U.S., Canada and Caribbean Operations, said, "We at Searle have been associated with practitioners of obstetrics and gynecology since before our introduction of the first oral contraceptive nearly 30 years ago. We are committed to helping physicians and the patients they serve find a way out of this malpractice crisis that is so fundamentally damaging to our system for quality health care delivery. We hope the Searle Alliance for Health Care becomes a catalyst to bring together parties who can effect solutions."

At the heart of this initiative, Bethune said, the Searle Alliance, in conjunction with Harvard University, will sponsor a panel of distinguished experts who will explore policy alternatives in hopes of shaping future legislation. This effort will culminate in a public symposium this fall to consider policy recommendations.

Searle is a research-based company which develops, manufactures and markets prescription drugs throughout the world. It is a wholly-owned subsidiary of Monsanto Company.

Ninth International Cuban Medical Association Congress set for summer

The Colegio Medico Cubano Libre announces its ninth international Cuban Medical Association Congress to be held June 28 through July 4 at the Sheraton Bal Harbour Hotel in Miami Beach.

Registration for the meeting is $300 prior to June 13, $310 after that date. The Congress features an outstanding scientific program with Plenary sessions

from 8:30 a.m. to 1 p.m. and meetings for different specialties from 2 p.m. to 6 p.m.

A five-hour Category 1, AMA credit Risk Management Seminar will feature a lively and entertaining social program in addition to the post congress cruise to Alaska, which is scheduled for July 5 through July 23. The cruise will visit Las Vegas, San Francisco, Seattle and Vancouver.

For more information and registration details please write or call: Cuban Medical Association, 213 Aragon Ave., Coral Gables, FL 33134. Phone: (305) 446-9902.

Sea World salutes the medical industry

Sea World is proud to recognize the dedicated employees of the medical industry with a special admission June 19 through 21 that will include a hamburger cookout at the Atlantic Picnic Pavilion.

Sea World offers a full day of family entertainment with seven major shows and numerous displays and exhibits. "Baby Shamu Celebration"™ explores and explains the evolution of man's relationship with killer whales and introduces the newest member of the Sea World family, Baby Shamu.™ "New Friends" teams four species of whales and dolphins in an entertaining and educational show. "Sea Lions of the Silver Screen" stars sea lions Clyde and Seamore in a lighthearted theatrical spoof. "Ski Pirates" features swashbuckling waterskiing feats. "A Little Night Magic"™ is an evening of entertainment that features special shows and a spectacular fireworks finale.

Advance tickets including the luncheon are $18.75 for adults 12 and over (a $24.15 value) and $15.75 for children (3-11), (a $22.15 value). Tickets without the luncheon are $13.50 (a $18.95 value) for adults 12 and over and $10.50 (a $15.95 value) for children (3-11). For more information, please call (800) 432-1178 in Florida or (305) 345-4350 local. Sea World, open year-round, is located ten minutes south of Orlando at I-4 and the Bee Line Expressway.

DEAN'S MESSAGE

New academic pacesetters

As in any organization there is natural turnover of leadership, and a medical school is no exception. Within the past six months, the University of Florida College of Medicine has recruited four new department chairmen in the disciplines of Pediatrics, Radiology, Medical Microbiology, and Pathology after an exhaustive, national search.

Following the promotion of Dr. Gerold L. Schiebler to Associate Vice President for External Relations, Dr. Ian Burr joined the institution as Professor and Chairman of Pediatrics. Dr. Burr is a native of Australia where he received his medical degree. Following six years of pediatric residency and endocrinology fellowship in pediatric endocrinology at the University of California at San Francisco. After a two-year stint at the University of Geneva in Switzerland, Dr. Burr joined the faculty of Vanderbilt University School of Medicine as Head of the Division of Pediatric Endocrinology while also serving as a Howard Hughes Medical Investigator. For six years, he also served as Director of the Genetics Division at Vanderbilt. Active in numerous state and national organizations, including membership on the medical advisory board of two national diabetes foundations, Dr. Burr maintained an active research interest resulting in over 130 scientific publications. He is a diplomate of the American Board of Pediatrics and the American Board of Pediatric Endocrinology.

Shortly after the arrival of Dr. Burr, Dr. Edward V. Staab joined our faculty as Professor and Chairman of the Department of Radiology. Dr. Staab is a native of New York and received his undergraduate and medical education in Minnesota. Following a residency in radiology at the University of Minnesota, he served for two years in the U.S. Army. Upon completion of his military obligation, Dr. Staab joined the faculty at Vanderbilt where he remained for five years before becoming Chief of the Division of Imaging at the University of North Carolina School of Medicine at Chapel Hill. In 1979 he became Associate Chairman of the Department of Radiology at North Carolina. He has served in numerous elected and appointed positions of the American College of Radiology, Radiological Society of North America, Society of Nuclear Medicine, North Carolina Medical Society, and the American Roentgen Ray Society. He is currently a member of the American Board of Nuclear Medicine. Dr. Staab has authored nearly 20 book chapters, over 100 scientific papers, and 80 scientific abstracts. He is a diplomate of the American Board of Radiology and the American Board of Nuclear Medicine.

In January 1987 Dr. Richard W. Moyer became Professor and Chairman of Medical Microbiology. A native of Baltimore, he received his education at Pennsylvania State and the University of California at Los Angeles. After a two-year postdoctoral fellowship at Massachusetts Institute of Technology, he joined the faculty of microbiology at Columbia University. Since 1976 Dr. Moyer has served on the microbiology faculty at Vanderbilt University School of Medicine. An expert in the gene regulation of mammalian DNA viruses, Dr. Moyer serves on several national scientific committees including an editorship of the journal *Intervirology*. He is the recipient of several professional awards and has contributed extensively to the scientific literature.

Recently Dr. Noel Maclaren became Professor and Chairman of the Department of Pathology. A native of New Zealand, Dr. Maclaren received his basic medical training in his native land and in London. Following a faculty appointment at the University of Maryland School of Medicine, he joined the Department of Pathology at the University of Florida College of Medicine in 1978. Active in numerous national and international scientific groups, including membership on the Juvenile Diabetes Foundation Medical Advisory Board, his active area of research has been the pathogenesis of autoimmune diseases including including insulin-dependent diabetes. His research has resulted in more than 25 book chapters, over 75 scientific papers, and 70 abstracts.

The talents and expertise that these new academic pacesetters bring to the University of Florida College of Medicine will help propel this medical school to the next level of excellence in education, research, and patient care.

William B. Deal, M.D.
Dean and Associate Vice President
for Clinical Affairs
College of Medicine
University of Florida

ENCORES!

Medicare's newest blunder?

This month's hot medical topic in Washington, D.C. is catastrophic insurance for Medicare age patients. It has largely been spearheaded by Secretary of Health Otis Bowen, M.D., a conscientious physician who seems to have the best interests of the populus at heart.

The current administration has taken this very popular proposal and chosen to embrace it, as a tool for recouping lost appeal with the elderly, even through powerful cabinet members such as Ed Meese opposed it when initially presented. Whenever it seems that the administration is addressing the needs of the elderly, it congratulates itself as a sensitive and caring, benevolent entity, and for that fraction (less than 2%) of patients whose share of this care under the present plan exceeds $2,000, and who lack co-insurance, this is a generous proposal and a relief from worries.

However, the millions of patients who require extended non-hospital care continue to be ignored. Several senators and congressmen including Congressman Claude Pepper and representatives of senior citizen groups have been quick to identify the shortcomings of the President's (Secretary Bowen's) Plan—the largest of which is a lack of provision for long term care.

Terminally ill patients, or those in need of long custodial care, create a tremendous emotional drain on the families. The amount of psychic energy required to deal with a parent, spouse or the loved one who is totally debilitated, is tremendous. This all too frequent tragedy is even more frequently compounded by the shocking news delivered by medical staff that only patients who qualify for medicaid (i.e. are totally destitute) are covered for long term care. Medicare will cover short term rehabilitation or brief home health services but will not finance around-the-clock care of any kind for these patients.

It is painful to explain to families that the only way for their loved one to qualify for such care is for them to very nearly exhaust all of their worldy possessions and savings. When they demonstrate that they are sick, impoverished and hopeless, then the government will cover their care (in 3-4 weeks, after the paperwork is complete)—of course DRGs/PROs will not allow them to await the qualification period in the hospital. Therefore families are forced with providing their share of the current $32 billion spent annually by families of chronically ill for nursing home care.

Of course, personally financed insurance for this care has become increasingly available recently, thanks to the insurance industry looking to capitalize on the growing senior population. The $20,000 to $30,000/year cost of caring for a person in a nursing home make such coverage impractical for lower and middle income families. Footing the bill independently is equally impractical.

The inclusion of long term care has been proposed separately by Congressman Pepper, Congressman Roybal and others. Some plans include long term coverage and more importantly—a means test for qualification and a cap on contribution and cost. This is the only equitable way that we can continue to provide adequate short and long term health care for our senior citizens.

It remains for Congress to work out the details in a fiscally-sound program but the time for addressing this issue is now. We must provide a comprehensive plan and not permit the administration's short-sighted analysis to prevent Congress from passing breakthrough legislation in this legislative session.

Richard Hays, M.D.
West Palm Beach

Reprinted with permission from *On Call*, Palm Beach County Medical Society, April 1987.

Health care in a dreamworld

The remarkable achievements of medical science and technology, and the social, economic and political responses to these achievements have produced a kind of dreamworld in health care. Depending upon one's point of view, the dreams may be good or bad. In any case, it is not nature's way to dream forever. It is reasonable to expect that someday there will be an awakening and it will be discovered that the dreams were never real, and that reality is something different.

The dreams are many. Some are the dreams of society as a whole, some are of health planners wherever they may be and some are of physicians, other health professionals or the medical profession itself. Most are all too familiar:

- A free market and profit incentives in health care will, over time, solve the problems of health care distribution and will lower costs.
- Competition will provide a better product at lower cost, as it has done in so many other aspects of American life.
- The excess numbers of physicians and other health care providers will meet, or more than meet, the needs for health care services in medically underserved areas.
- Medical science should, by now, achieve near perfection in health care or someone or something must be to blame.
- Medical science has now displaced the need to study and practice the traditional art in patient care.
- Prevention and health education will reduce health care costs because fewer people will get sick and everyone will live longer.

All these are fantasies, often heavily laced with wishful thinking. Yet it is beliefs such as these that seem to dominate a dreamworld of health care in which this nation now finds itself.

Then there are some really bad dreams. For some they may even seem like nightmares. Funding for the care of the poor, the disadvantaged and underprivileged is being more or less systematically reduced, with now measurable deterioration in the health status of many of them. Physicians are finding themselves no longer always in charge of patient care but nevertheless being held individually and collectively responsible for it in the minds of the public and in the courts of law. Medicare, Medicaid, DRGs, PROs, government regulations and the requirements of private sector payors in patient care all too often are producing costly administrative nightmares for physicians and hospitals and siphoning off dollars that might otherwise be used to provide needed care. And then there are conflicts among physicians and conflicts with hospital administrators and with other health professionals who may seek to occupy more and more of physicians' role and turf. The list of bad dreams could go on and on. As physicians know, the list these days is a long one.

But sooner or later there must come an awakening. It will never be profitable to provide care for those who cannot pay. There is accumulating evidence that the health of disadvantaged youth, particularly among the minorities, is worsening. The free market makes a travesty of anything like equity in health care. Medicine is not an exact science and never will be. It is also a fact that the longer more people live, the more health care they may be expected to consume, with the attendant greater costs. It is a reality that there will never be enough dollars to do everything we now know how to do for every patient. Yet at the same time dollars are being spent for frills, profit-making ventures and the like, rather than on genuinely needed health care. After all, health care is for people, not just for governments, corporations, investors or profiteers. Denied or deferred care is not likely to be cost effective for patients or for society.

What to do? Will this dreamworld go on forever? It is patently unrealistic and inefficient. As someone has said, health care has become a crazyquilt of patchwork of ad hoc interventions, usually based on incorrect assumptions, that in general have created more problems than they have solved. As a result many of the solutions are now becoming the problems. Perhaps it is time to get back to some fundamentals such as:

- Recognize the important but actually limited role of medical science and technology in overall patient care.
- Study, define and perhaps even begin to measure what goes on in a clinical encounter between doctor and patient, and what it takes to give satisfaction to both.
- Address the social, economic and political issues that arise from medical progress, whether in individual patient care of elsewhere in the health care enterprise, and seek consensus among the interested parties about what to do and how to do it.

Conflicting interests abound in all of this, and in the real world of health care way must be found to balance these various interests in what will always be dynamic and changing situation. In the meantime the dreams and the nightmares both run rampant in the professional and public consciousness, or perhaps one should say unconsciousness. In the meantime, much that is valuable in health care is being unnecessarily lost to patients and to society.

Malcolm S. M. Watts, M.D.

Reprinted with permission from *The Western Journal of Medicine*, April 1987.

The threatened face of medicine

For a physician to practice at a level of excellence in medicine, it is generally acknowledged that he remain up to date, be competent in his field, and committed to his patients. In addition the resources required by his patients' needs, the preservation of the doctor-patient relationship, and the survival of the traditional, ethical and moral values of medicine play major roles.

Resources seem to be particularly affected in the Medicare group of patients. Government edicts such as DRG's virtually assert a form of rationing of healthcare with secondary erosions into both the doctor-patient relationship and into the ethical and moral values. Some important questions come to mind:

- Can the doctor protect his patients' interests adequately where resources are limited?
- How often does the physician in treating the hospital patient have to fight a rear-guard action, which pits him against the hospital administration striving to balance their budgets?
- Will the lid on resources drive the Medicare System into mediocrity?
- Are doctors being slowly forced into the role of "income promoters" to the possible harm of their expensive-to-treat chronically ill patients?

In partial answer to these questions, the physician must insist on a managerial role, whatever the health care setting, in order to play his full part as protector of his patients' faith. In other words, cost-containment should ideally be doctor-inspired and be flexible, rather than controlled by rigid statutes as it has now become. In the United States so-called commercial "market forces" are exerting their own cost controls. The doctor has been asked, in many cases, to do it cheaper rather than better. However, the patient, no fool, does know the difference! Increasingly many HMO's are insisting (because of demand) on quality control, as well as utilisation control.

In summary, the doctor must be allowed to do what he is fully trained to do. He must continue to be motivated in his patients' best interests, to be propelled by ethical and moral values, but at the same time exercise sensible cost controls relative to the patients' condition. In the final analysis, the commitment of the physician to his patient's welfare remains paramount. Where the commitment is considered in doubt we will deserve to be treated as any other commercial interest group. Where this commitment remains strong, we will earn the respect and loyalty of our patients, and be able to speak with assertion on their behalf.

Vernon H. Bartley, M.D.
Tampa

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America's health care revolution: Who lives? Who dies? Who pays?

By Joseph A. Califano Jr., 241 pages. Price: $17.95. Random House, New York, 1986.

This book holds out rich promise of becoming a landmark publication in health policy. Because of the author's background (he was Secretary of the Department of Health, Education, and Welfare [DHEW] in 1977-79), we expect a lot. He tells of his success in lowering the costs of medical care at Chrysler. He then moves on to the "health industry," physicians ("medicine men and women"), hospitals ("the temples of the medicine men"), the insurance industry ("profitable acolytes"), government agencies, cost shifting ("the great health care shell game"), and nursing homes. Then, in the final chapter, he gives his perscription for setting all these difficulties right. With this author and such scope, how can you lose?

Sadly, the book has some serious flaws; I can deal with only a few.

The author tells his own stories of regulatory negotiations in government. These are interesting and revealing, but there is never a reference for his statistics—only a gratuitous unrefined list of "sources" at the end of the book. In the first few pages we learn that he admires American business and American businessmen (curiously, he never mentions American businesswomen). But at the same time he scorns physicians, whom he refers to as "medicine men and women" throughout the book.

Mr. Califano is clearly proud of his role on the board of Chrysler in helping that corporation cut its health care costs. In a gripping and frank account, he tells of his own unsuccessful efforts to do something about the tobacco and alcohol industries when he was at DHEW, but there is no mention of his other work there, of the swine flu fiasco, the death of the Regional Medical Programs, the failure of the Professional Standards Review Organization legislation, the imminent bankruptcy of and cutbacks within Medicare, or any of the other activities of the federal health bureaucracy of DHEW and the Department of Health and Human Services in the late 1970s and early 1980s. These should have been part of his story.

His reverence for business is seen in his glowing description of the motivations and methods of businessmen. Many readers may share my skepticism and may ask if these are not the same people who brought Chrysler to the brink of bankruptcy before the taxpayers rescued it. Are these the American businessmen who lost railway and airline services to small towns and communities that now, we learn, have even lost their bus service?

There is an interesting analogy here. Small towns are the counterpart, in transportation, to the poor and undeserved in medicine. Both are a sure fiscal loss over the short term, poorly served in an exclusively profit-oriented industry. What is to make us believe, as Mr. Califano clearly does, that handing over control of heatlh care for the poor to a group of business executives will have any better result than they achieved in providing transportation to small towns?

As a result of his experience at Chrysler, Mr. Califano now wants to introduce more competition into American medicine. It will be a bit hard for some readers to understand the origin of that confidence in competition, since Chrysler lost out in the

competitive automobile market and then got the taxpayers to bail it out. It that what we call "facing up" to adverse results and the healthy "weeding out" process of competition?

In contrast to the wonders of American business, the picture that Mr. Califano paints of "medicine men and women" is a dismal one at best. According to him, physicians (through the American Medical Association) have been trying to achieve and maintain a monopoly over medical care for the past hundred years. In point of fact, Western medicine (read "scientific medicine" if you like) gained its edge over competing cult practitioners not through political maneuvering but through the repeated demonstration that its application of bioscience to the diagnosis and treatment of disease resulted in safer and more effective medical care.

The author is certain, as are many others, that we are producing too many physicians. But wait, Mr. Califano has a whole new job for medicine men and women: They are to supply "wellness care." The author seems to be unaware that Western medicine has operated in the complaint-response mode for centuries if not millennia. There are about 75 million nonusers of medical care in the United States, mostly young, healthy, fully employed men. These are people (not patients) who are quite well, do not go to physicians, do not want physicians, and believe that they do not need physicians. Many have very bad habits: too much alcohol, food, and unprotected sex. How is the physician to change their habits?

Although physicians are to provide a lot more wellness care, the author showers praise on a company (Berol) that, by increasing copayment and deductibles and by offering a reward for "no physician contacts" by its employees, could report that under their new policy there were very few claims for medical care. Is this "wellness care"? It sounds more like a company of cowed employees, beaten down by their bosses, rewarded for not seeing a doctor even when ill, and told to pay out of their own pockets if they do consult one.

Mr. Califano's image of the physician over the past hundred years is that of a "medicine man" plotting, "How can I make money by treating this person, even if he doesn't need it?" Now, as business ethics and cost consciousness are introduced into the system, he would have the physician consider, "How can I make money by not treating this patient, even if he needs it?"

Mr. Califano's final recommendation chapter is a disappointment. Although he does set out some prescriptions for change that are worth studying, he spends the largest portion of this chapter inveighing against smoking—always an easy position to take and a popular one. Fortunately, smoking is one of the few of our disordered life styles that have already shown a clear and measurable improvement over the past 15 years. Mr. Califano probably deserves some credit for this improvement.

I advise all physicians to read Mr. Califano's book to understand what we are up against if present health policies continue to prevail. If we do not understand what he is saying, we may be unable to do more than plead for old-fashioned scientific and ethical imperatives while the regulators successfully replace them with fiscal incentives adverse to every aspect of patient welfare.

Francis D. Moore, M.D.
Harvard Medical School
Boston, MA

Reprinted with permission from *New England Journal of Medicine*, Vo. 316, March 26, 1987.

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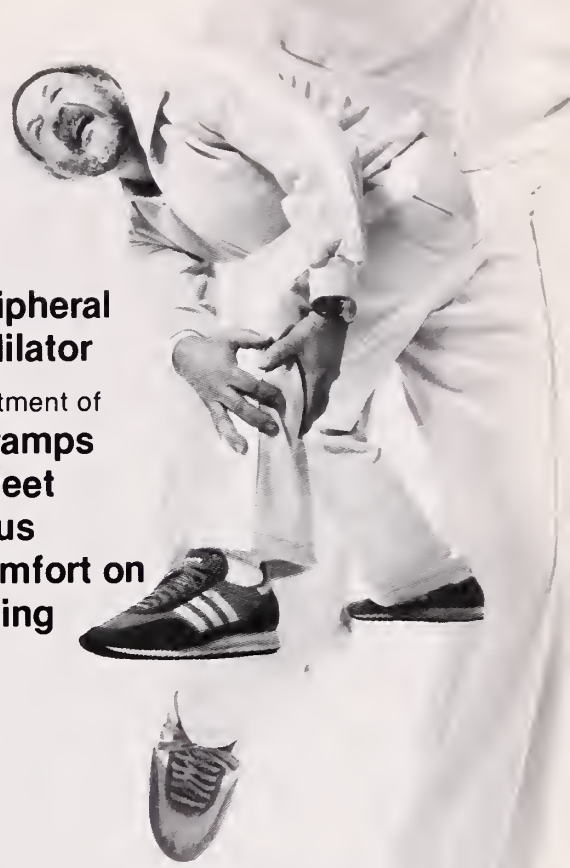
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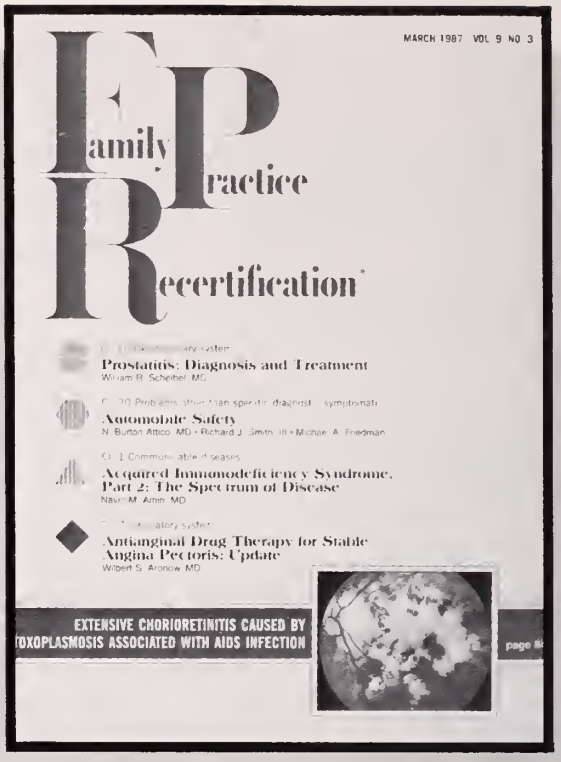
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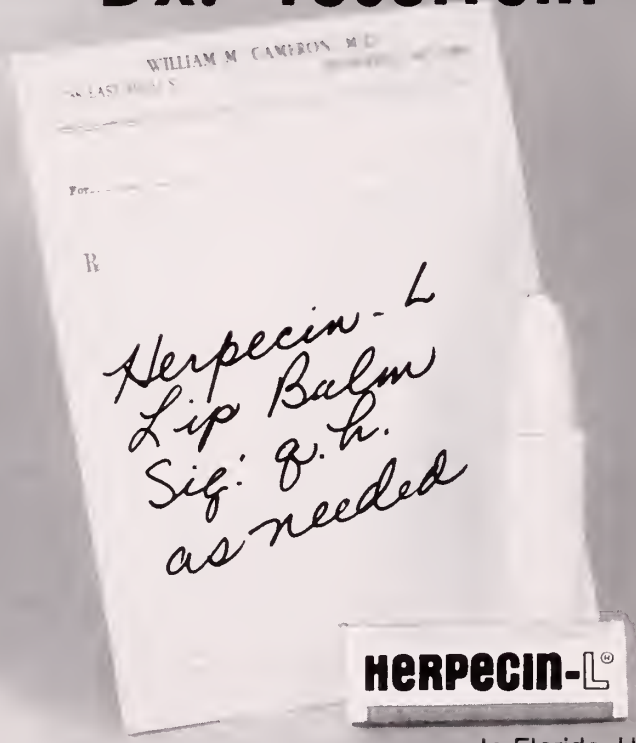
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Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Auxiliary aims adapt to current needs and issues

In 1926 the objectives of the Florida Medical Association Auxiliary were formulated to include the following objectives: (1) to extend the aims of the Association to the wives of the doctors; (2) to extend the aims of the Association to other organizations which look to advancement in health and education; (3) to assist in entertaining at state and county medical society meetings; (4) to promote acquaintance among doctors and their families, that close fellowship may exist; (5) to do such work that may be assigned from time to time by the Association. In the years that followed, Auxiliary aims continued this same course, but with emphasis shifting to the issues and needs prominent for that period of time. In the '30s, public health problems were utmost in importance: hookworm, malaria, cancer, tuberculosis and venereal disease. These were the topics of the day.

In the Legislature, bills were introduced that would have allowed charlatans, quacks and others to prey on the residents of Florida. The Auxiliary was asked to assist in defeating these bills.

During the '40s, some Auxiliaries had to disband because of the decrease in membership brought about while physicians were away from home serving in the Armed Forces. Auxiliary wives were busy in their home communities as Red Cross volunteers, hospital auxiliary workers and Canteen ladies. Auxilians were also called upon to sell United States War Bonds and Stamps. Sales of more than $700,000 were reported.

As the '50s arrived, the Florida Auxiliary, under the administration of Mrs. Perry D. Melvin (Miami), incorporated and defined the aims of the Auxiliary as follows: (1) to assist the Association in its program for the advancement of medicine and public health that philanthropic and educational programs may be conducted for the betterment of the heatlh needs of the people of Florida; (2) to coordinate and advise the activities of chartered component auxiliaries as deined in the Articles of Incorporation; (3) to promote health education; to encourage participation of volunteers in activities that meet health needs; and to support health-related charitable endeavors; (4) to receive and disburse gifts for the promotion of the objects and purposes of the corporation.

The Handbook of Guidelines was developed to help clarify the relationship between county, state and national auxiliaries.

A major success in the Legislature of the '50s resulted in voluntary health insurance programs. The early '60s saw emphasis on improving public relations, Future Nurses Clubs, and disaster preparedness. Membership increased to more than 3,000 and reached 4,000 in the '70s. As a sign of the changing times, the name of the Auxiliary was changed from Woman's Auxiliary to Florida Medical Association Auxiliary. During this decade of the '80s, membership soared to 6,000 but has now stayed at 5,000. Since the Auxiliary is now more than 60 years old, Auxiliary President Susan Marks has appointed the First Vice President in charge of Membership, Jane Eberly, to the Chairmanship of the Ad Hoc Committee on Action Planning to identify specific activities that need to be enhanced, initiated, redirected or dropped. It was found that we have had the same 20 committees, sometimes adding or deleting one, renaming it, or placing it under a different category. The same meeting structure has continued with convention, conference, leadership and spring workshops.

Through the years we have stayed on the same course. Perhaps it is time to address a change! The male spouse is a new entity among our membership. Today's spouse often has a career of his/her own. It is vital that today's Auxiliary reflect the changing times.

It is perceived that future Auxilians will be deeply involved in support programs for the physician and his/her family as we struggle to cope with the liability crisis and the legislative issues of the day. Programs and projects may be adapted to meet contemporary issues and needs; however, the need for close fellowship among medical families will always be in vogue.

Mrs. Arthur (Jane) Eberly
First Vice President, FMA Auxiliary
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Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

JUNE

The Florida Society of Clinical Hypnosis Annual Meeting & Workshop, June 5-7, Sundial Resort, Sanibel Island. Contact: Charles B. Mutter, M.D., (305) 547-2000.

Flexible Sigmoidoscopy Workshop, June 6, Hyatt Regency, St. Petersburg. Contact: Peter Pardoll, M.D., (813) 384-2016.

Family Practice '87, June 8-11, Hilton Hotel, Orlando. Contact: Thomas Stewart, M.D., (912) 452-2213.

Eighth Annual Child Neurology Postgraduate Course, June 8-11, Sonesta Beach Hotel, Key Biscayne. Contact: Oscar Papazian, M.D., (305) 663-8330.

Thirty-eighth Florida Academy of Family Physicians Annual Scientific Assembly, June 10-14, The Stouffer Orlando Resort, Orlando. Contact: Donald B. Twiggs, M.D., (904) 398-5667.

1987 Joint Florida Perinatal Conference, June 11-13, PGA Sherator Resort, Palm Beach. Contact: Judy Sommers, (813) 974-3623.

The Partners in Perinatal Health: 1987 Joint Florida Perinatal Conference, June 11-13, PGA Sheraton Resort, Palm Beach. Contact: Stanley N. Graven, M.D., (813) 974-3623.

Workshop: Excercise Stress Testing in Ambulatory Cardiac Monitoring, June 12, Stouffer Orlando Resort, Orlando. Contact: Donald B. Twiggs, M.D., (904) 398-5667.

Contemporary Issues in Medicine, June 12-14, Amelia Island Plantation, Amelia Island. Contact: Jeanette Stone, (800) 423-4992.

Diagnosis and Management of Respiratory Disease, June 19-21, Dutch American Hotel, Orlando. Contact: Deborah Wilderson, (303) 798-9682.

Pediatric Risk Management Seminar, Tradewinds Resort, St. Petersburg. Contact: Thomas N. Hennessy, M.D., (813) 734-6405.

Twelfth Annual Florida Suncoast Pediatric Conference, June 21-24, Trade Winds Resort, St. Petersburg. Contact: Paul B. Welty, M.D., (813) 323-1804.

Two-Dimensional Echocardiography, June 22-26, Orlando. Contact: American College of Cardiology, (800) 253-4636.

Cardiac Function in Health and Disease Conference, June 25-26, Sheraton World Hotel, Orlando. Contact: Rick Mace, (305) 897-1575.

Ninth Annual Cuban Medical Association Congress, June 28-July 5, Sheraton Bal Harbour, Bal Harbour. Contact: M. Viamonte Jr., M.D., (305) 674-2680.

JULY

Primary Care & Preventive Medicine, July 8-11, Peabody Hotel, Orlando. Contact: Drs. A. Varraux & J. Herran, (305) 841-5144.

1987 Clinical Conference on Pre-Hospital Emergency Care, July 9-12, Orlando Hyatt, Kissimmee. Contact: Registrar, (305) 628-4800.

AUGUST

Fourteenth Annual Review Course for Certification in Internal Medicine, "Fundamental and Clinical Aspects of Internal Medicine," August 2-15, Key Biscayne Hotel and Villas, Key Biscayne. Contact: Jose S. Bocles, M.D., (305) 547-6063.

Coronary Heart Disease: Current Concepts, August 14-15, Orlando Hyatt Hotel, Orlando. Contact: Karen DeBent, (800) 421-3756.

American Heart Association ACLS Instructor Course, August 29-30, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

SEPTEMBER

Annual Pediatric Symposium — 1987, Sacred Heart Hospital, Pensacola. Contact: Barabara J. James, (904) 477-4956.

Doppler Echocardiography Seminar, September 10-12, Innisbrook Resort Conference Center, Tarpon Springs. Contact: Registrar, Ultrasound Center, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, N.C. 27103 or call (919) 748-4505.

Magnetic Resonance Imaging: A Technologist's New World, September 10-12, Peabody Hotel, Orlando. Contact: Martin Silbigu, M.D., (813) 974-2538.

Head & Spinal Cord Injury, September 17-18, Pensacola. Contact: Phyllis Connerley, (904) 478-4460 ext. 4178.

Current Concepts in the Diagnosis and Management of Adult Heart Disease, September 18-19, New World Landing, Pensacola. Contact: (904) 478-4460.

OCTOBER

The Friary's Sixth Annual Professional & Chemical Dependency Seminar, October 2, Pensacola Beach. Contact: Brunie Emmanuel, (904) 932-9375.

Emerging Trends in Critical Care—1987, October 7-9, Crowne Plaza Hotel, Orlando. Contact: Rick Mace, (305) 897-1575.

Magnetic Resonance Imaging, October 29-23, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Thirteenth Annual Gulf Coast Internal Medicine Conference, October 28-30, Pensacola Hilton, Pensacola. Call: (904) 474-7100.

Twenty-eighth Workshop in Electrocardiography, October 28-31, Sheraton Sand Key, Clearwater Beach. Contact: Henry Marriott, M.D., (813) 894-0790.

Fifth Annual Advanced Neuroradiology, October 29-31, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, (813) 974-2538.

NOVEMBER

Primary Care Update: Seventy-second Scientific Assembly, November 2-5, Diplomat Hotel, Hollywood. Contact: Ray W. Gifor Jr., M.D., (608) 257-6781.

Advanced Applied Ultrasound in Obstetrics, November 5-7, Bowman Gray School of Medicine, Naples. Contact: Regsitrar, Ultrasound Center, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, N.C. 27103 or call: (919) 748-4504.

American Heart Association ACLS Instructor Course, November 7-8, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Thirteenth Annual OB/GYN Pathology Course, November 12-15, Doral Hotel-on-the-Ocean, Miami Beach. Contact: Patti Mundy, Department of OB/GYN, University of Miami, P.O. Box 016960, R-116, Miami, FL 33101.

Flexible Sigmoidoscopy, November 14-15, Sonesta Beach Hotel, Key Biscayne. Contact: John P. Christie, M.D., (305) 687-1367.

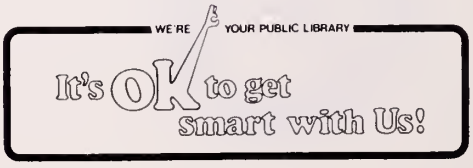
All America's Health '87, November 15-18, Curtis Hixon Convention Center, Tampa. Contact: Pierre J. Bouis Jr., M.D., (813) 974-4296.

DECEMBER

Clinical Allergy & Immunology for the Practicing Physician, December 3-5, Buena Vista Palace, Lake Buena Vista. Contact: Richard F. Lockey, M.D., (813) 972-7631.

Diagnosis & Management of Respiratory Diseases, December 4-6, Boca Raton Hotal, Boca Raton. Contact: Karen DeBont, (800) 421-3756.

1987 FINA World Medical Congress, December 5-8, Justus Aquatic Center/Radisson Hotel, Orlando. Contact: Allen Richardson, M.D., (303) 578-4575.



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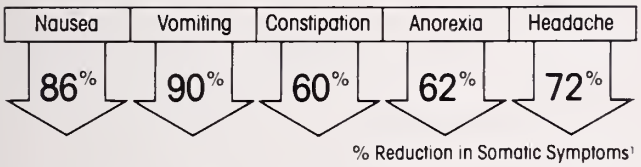
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References: 1. Feighner JP, *et al: Psychapharmacology 61*.217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ

Limbitrol® Ⓝ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary af which follaws:
Indications: Relief of moderate ta severe depression assaciated with moderate ta severe anxiety
Contraindications: Known hypersensitivity ta benzadiazepines or tricyclic antidepressants. Da not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Use af minar tranquilizers during the first trimester should almost always be avaided because af increased risk af congenital malfarmatians as suggested in several studies. Consider possibility af pregnancy when instituting therapy; advise patients ta discuss therapy if they intend ta ar da become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physastigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
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THE JOURNAL OF THE
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P.O. BOX 2411
JACKSONVILLE, FLORIDA 32203



The Liability/Health Care Crisis

June 19, 1987

URGENT PRESIDENTIAL MEMORANDUM

To: All FMA Members
Subject: Professional Liability—Special Session/Constitutional Amendment Signature Petition Campaign

Dear Colleague:

I am writing to you to provide you with an update on the professional liability crisis and to appeal for your help in the crucial months ahead in support of your Association's continuing efforts to resolve this worsening situation. I hope that you will review carefully the information included in and enclosed with this memorandum.

As you know, the Florida Legislature adjourned its regular session on June 5 without having enacted any tort reform measure. The FMA was advised by the House and Senate leadership prior to the 1987 session that no tort reform measure would be considered until the Academic Task Force, created by the 1986 Legislature, completes its review of the entire liability problem and submits its report and recommendations to the Legislature prior to the 1988 session.

Unfortunately, two things happened that caused the crisis to worsen even more. First, the cap of $450,000 on the amount that can be awarded for noneconomic damages in liability suits enacted as part of the 1986 Comprehensive Liability and Insurance Reform Act was declared unconstitutional by the Florida State Supreme Court. Secondly, the St. Paul Insurance Company, the state's largest medical liability insurance carrier, and CIGNA Insurance Company announced their intentions to withdraw from the medical liability market in Florida after July 1. This action, if carried out, would leave between 7,000 and 8,000 physicians without liability insurance protection if they are unable to obtain coverage from other carriers remaining in the market.

The FMA immediately sought to have the Legislature enact legislation during the 1987 session calling for a proposed constitutional amendment to be placed on the 1988 general election ballot that would cap noneconomic damages in all liability disputes. This proposal was not acted upon by the Legislature.

The FMA also sought and was successful in gaining the unanimous approval of the Senate for important legislation that would provide protection from liability for physicians and other health care providers in the hospital emergency and trauma setting. This bill also repealed the mandatory insurance provision of the 1986 law. Unfortunately, the House of Representatives did not approve this bill which would have provided much needed short-term relief to the crisis until such time as a long-term solution could be achieved.

State Insurance Commissioner Bill Gunter proposed as a solution to this crisis a mandatory insurance pool in which all physicians and hospitals would be required to participate. This proposal had serious implications for physicians as well as private enterprise and did nothing to address the legitimate cause of the liability problem, which the FMA feels strongly is our state's inefficient and inequitable tort system. Fortunately, that ill-advised proposal was defeated.

I am pleased to advise you that at the urging of FMA and others, **Governor Bob Martinez has taken a leadership role** in addressing the crisis. The Governor has indicated that he will call a special session of the Legislature, possibly in early September, to deal with the issue.

In preparation for a special session and other FMA action to resolve the PLI problem, your FMA Board of Governors at its meeting on June 13 approved the following actions:

1. THAT AN AD HOC COMMITTEE ON PROFESSIONAL LIABILITY BE APPOINTED TO BE CHARGED WITH THE PRIMARY RESPONSIBILITY FOR THE COORDINATION AND IMPLEMENTATION OF THE FMA'S PLI ACTIVITIES WITH APPROVAL OF THE BOARD OF GOVERNORS IN SUPPORT OF ITS STATED OBJECTIVES FOR **EVALUATION** OF THE MEDICAL INCIDENT COMPENSATION ACT (MICA) BY THE FLORIDA LEGISLATURE AS A RESOLUTION TO THE LIABILITY CRISIS, AND THE PLACING OF A CONSTITUTIONAL AMENDMENT ON THE 1988 GENERAL ELECTION BALLOT THAT WOULD PLACE A CAP OF $100,000 ON THE AMOUNT OF NONECONOMIC DAMAGES THAT MAY BE AWARDED IN ANY CIVIL LIABILITY DISPUTE.

 [*The Board of Governors, at a special called meeting with CMS officers on May 13, reaffirmed FMA's endorsement of the "Barron Plan," now called MICA, as a potentially viable alternative to the tort system for resolving liability disputes.*

 This plan, which **is not a no-fault program**, *has similarities to the State Workers' Compensation Act and maintains the requirement of proven negligence as the threshold for the recovery of damages. The plan embodies the following principle provisions:*

 * *The approach embodies certain elements of workers' compensation law.*
 * *It transforms the basis for malpractice suits from tort law to contract law.*
 * *It utilizes a scheduled benefit compensation system such as is utilized for workers' compensation.*
 * *It eliminates jury trials and adjudicates claims before a judge. Most cases would be resolved by the insurance carrier, and very few cases would be brought before a judge.*

* *Provider participation in the system would be mandatory. Each provider would be required, as a condition for licensure, to purchase medical incident insurance or be self-insured, as is now the law in Florida.*

* *In the event of a compensable injury, the mandated insurance would be the primary source of coverage for compensation.*

* *Claims for lost wages, rehabilitation and benefits for dependents would be unlimited in amount. Lost wages and benefits for dependents would be paid out periodically rather than in a lump sum.*

* *Damages for permanent disabilities or death would be limited to $100,000.*

* *The court would set reasonable attorneys' fees thus eliminating the contingency fees.*

* *The system would be self-executing in that types of losses would be defined, and claims for same would be filed with and handled by the provider, his carrier, or an independent administrative agency.*

The need for a constitutional cap on damages approved by the people of Florida is implicit if we are to guarantee that a limit on damage awards cannot be stricken down by a capricious act of the courts notwithstanding any statutory changes which may be enacted by the Legislature.]

2. THAT A SUPPORT GROUP OF OUTSIDE CONSULTANTS AS DETERMINED APPROPRIATE BY THE COMMITTEE BE DESIGNATED TO ASSIST THE COMMITTEE IN ITS ACTIVITIES.

3. THAT THE FMA PROVIDE FINANCIAL RESOURCES FROM SURPLUS FUNDS OF THE ASSOCIATION AND OTHER SOURCES THAT MAY BE IDENTIFIED TO CARRY OUT THE ACTIVITIES OF THE COMMITTEE RELATED TO THE SPECIAL SESSION.

4. THAT THE FMA CONDUCT AN IMMEDIATE PUBLIC OPINION POLL TO ASCERTAIN CURRENT PUBLIC ATTITUDES IN RESPECT TO THE PROFESSIONAL LIABILITY PROBLEM THAT HAS CAUSED A SERIOUS HEALTH CARE CRISIS.

5. THAT THE FMA REQUEST THE FLORIDA MEDICAL ASSOCIATION AUXILIARY TO IMMEDIATELY INITIATE A PETITION DRIVE FOR A 1988 REFERENDUM TO AMEND THE FLORIDA CONSTITUTION.

 [The FMA Auxiliary has accepted the challenge to organize and implement the initial phase of a signature petition campaign to obtain the signatures required to place a constitutional amendment on the election ballot. The Auxiliary's goal is to obtain 100,000 signatures of qualified Florida voters by September 1.]

6. THAT THE FMA ORGANIZE A PHYSICIAN/LAYMAN MARCH TO THE DISTRICT OFFICE OF EACH MEMBER OF THE FLORIDA LEGISLATURE AT LEAST ONE WEEK PRIOR TO THE SPECIAL SESSION.

7. THAT THE FMA WORK WITH THE LEADERSHIP OF THE HOUSE AND SENATE AND THE GOVERNOR'S OFFICE TO SOLIDIFY SUPPORT FOR THE FMA POSITION DURING ANY SPECIAL SESSION.

* 8. THAT FMA IMMEDIATELY ASK FOR VOLUNTARY CONTRIBUTIONS FROM ALL FMA MEMBERS AS WELL AS ALL LICENSED PHYSICIANS IN FLORIDA AND OTHER APPROPRIATE PROFESSIONAL GROUPS FOR A PUBLIC INFORMATION CAMPAIGN TO ESTABLISH A BASIS OF SUPPORT FOR THE FMA POSITION ON PROFESSIONAL LIABILITY; AND FURTHER, THAT COUNTY MEDICAL SOCIETIES BE REQUESTED TO ASSIST IN SOLICITING AND COLLECTING THESE FUNDS.

*The FMA has no remaining funds from the 1984 PLI assessment and the financial support of all FMA members is absolutely essential if we are to succeed in carrying out the professional liability objectives which I have outlined.

A **minimum** contribution of $500 per physician is needed to continue our efforts that will include a comprehensive public education campaign for gaining support for the FMA's legislative program in the special session and the constitutional amendment signature campaign. Please send your contribution of $500 or more today. A postage paid reply envelope is enclosed. **We cannot move forward without your help.**

The continuing availability of insurance after July 1 is of serious concern to many physicians. I am enclosing for your information a listing of those companies that we are aware of which are currently writing medical liability insurance coverage in Florida. In addition, it is still uncertain as to whether or not St. Paul will continue in the Florida market. Those of you who are currently insured by St. Paul have received information directly from the company regarding the status of your coverage.

It is important to note that prior acts (tail coverage) insurance may be provided by the Physicians' Protective Trust Fund (PPTF) to all qualified physicians at no additional charge for the tail coverage through the purchase of insurance through PPTF at a mature rate.

Florida Physicians' Insurance Company (FPIC), which is sponsored by the FMA, will provide tail coverage at no additional premium to qualified physicians in Classes 0-1-2 through the purchase of insurance at the mature rate. Physicians in Classes 3-7 may purchase tail coverage through their previous carrier and receive assistance in financing the tail coverage over a period of up to five years through an arrangement that FPIC has made with Southeast Banks. Physicians in Classes 3-7 may thus obtain coverage through FPIC at the first-year, claims-made rate which should equalize the total premium required as compared to a fully mature rate.

The 15-year struggle to resolve our state's liability problem has caused great hardship and a financial burden for physicians and the public. It now poses an imminent threat to the quality and access to vital health care services. However, through the relentless efforts of your county medical societies, the FMA and many individual physicians, there is growing support from all sectors for substantial action to resolve this terrible societal problem.

I need not remind you that there are those who will do everything possible to prevent a fair solution. We must continue our efforts with the total unified determination that a lasting and effective solution will be found. Can I count on your help?

Sincerely,

Jim Perry

James B. Perry, M.D.
President

enclosures

Florida Insurance Companies Writing PLI Policies

Florida Physicians Insurance Company (FPIC): 1-800-342-8349; (904) 354-5910

Taking new insureds?	Yes
Number currently insured?	2,542
Offering tail coverage?	Considering retroactive coverage for class 0, 1, and 2
Type of policy?	Claims made
Assessable?	No
Levels of coverage?	100/300, 250/750, 500/1.5 mil, 1 mil/3 mil, 1.5 mil/4.5 mil

Physicians Protective Trust Fund (PPTF): 1-800-222-5115

Taking new insureds?	Yes
Number currently insured?	4,000
Offering tail coverage?	Yes
Type of policy?	Claims made
Assessable?	Yes, self-insured up to $150,000—has never had an assessment
Levels of coverage?	Ten levels from $100,000 up to $2 million

Florida Physicians Insurance Trust (FPIT): (904) 386-1111

Taking new insureds?	Not writing OBs statewide nor ER in South Florida
Number currently insured?	1,000
Offering tail coverage?	Yes
Type of policy?	Claims made
Assessable?	Assessable
Levels of coverage?	100/300, 250/750, 500/1 mil, 1 mil/3 mil

Caduceus Self-Insurance Fund, Inc.: 1-800-432-3439; (305) 621-3440

Taking new insureds?	Dade and Broward no class 5 or above, rest of state no class 6 or above
How many currently insured?	750
Offering tail coverage?	Yes
Type of policy?	Claims made
Assessable?	Assessable
Levels of coverage	100/300, 250/750, 500/1 mil, 750/1.5 mil

Anesthesiologist Professional Assurance Trust: (305) 279-7870

Taking new insureds?	Only anesthesiologists
How many currently insured?	450
Offering tail coverage?	Yes
Type of policy?	Claims made
Assessable?	Assessable
Levels of coverage?	250/750, 500/1 mil, 500/1.5 mil, 1 mil/2 mil, 1 mil/3 mil

Paragon: (305) 963-6400

Taking new insureds?	Only class 2-3 Urologists
How many currently insured?	186
Offering tail coverage?	Yes
Type of policy?	Claims made
Assessable?	Assessable
Levels of coverage?	250/750, 500/1 mil,1 mil/1 mil

South Pinellas Medical Trust: (813) 327-1141

Taking new insureds?	Only South Pinellas County
How many currently insured?	137
Offering tail coverage?	Case by case basis
Type of policy?	Claims made
Assessable?	Assessable
Levels of coverage?	250/750, 500/750, 1 mil/3 mil

CONFIRMED

CONFIRMED BY CLINICAL EVIDENCE

ZANTAC® 150 h.s.

ranitidine HCl/Glaxo 150 mg tablets

EFFECTIVE MAINTENANCE THERAPY

for healed duodenal ulcer patients

See last page for references and
Brief Summary of Product Information.

Glaxo / ROCHE

CONFIRMED

In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

Percent of patients with observed duodenal ulcer recurrence

		0-4 months	0-8 months	0-12 months	No. patients
USA[1]	ranitidine 150 mg h.s.	9%	14%*	16%†	60
	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia[2]	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

*p=0.02
†p=0.01
‡p≤0.004
%=life-table estimates
All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a

low incidence of side effects[3]

Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the **ADVERSE REACTIONS** section in the Brief Summary.

No significant interference with the hepatic cytochrome

P-450 enzyme system at recommended doses

ZANTAC 150 mg has no significant drug interactions with theophylline, phenytoin, or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications that decrease gastric acidity are administered.

Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime
for maintenance

See next page for references and
Brief Summary of Product Information.

Glaxo / ROCHE®

CONFIRMED

Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime for maintenance therapy in healed duodenal ulcer patients

References:

1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.
3. Data available on request, Glaxo Inc.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

The following is a brief summary only. Before prescribing, see complete prescribing information in ZANTAC® product labeling.

INDICATIONS AND USAGE: ZANTAC® is indicated in:

1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to ZANTAC® administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION. Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

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UAB Medical Center
Center for Health Professionals

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JUNE 1987, Vol. 74, No. 6

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This month's cover of *The Journal* depicts the Special Article, "Motorboat Propeller Injuries" by Charles W. Price, M.D. and Charles W. Moorefield, M.D. The photograph is by Jacksonville photographer David H. Fauss of PHOTOworks.

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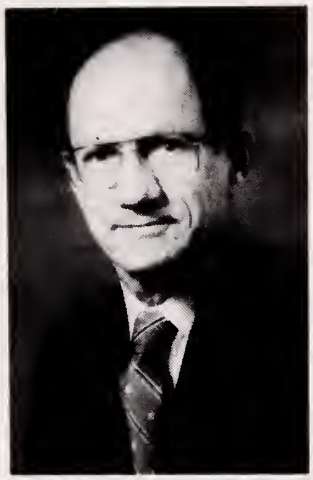
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FAIR OAKS HOSPITAL
AT BOCA/DELRAY

PRESIDENT'S PAGE

A retrospective of the session

Just one day in the life of ...



With the apparent decision of the St. Paul Insurance Company to discontinue in the liability market in Florida after December 31 and the decision of CIGNA Insurance Co., to totally stop writing this type of insurance throughout the entire country, we have entered a new era. The fallow, hallowed work and pomp of the trial bar concerto and the mouthing of its fallacious philosophy serves to illustrate the depravity of human nature and the self-serving, nonsensical uselessness of the warped argument. Nevertheless, it is perceived by most, even casual, observers as truth.

I write this page with a deep sense of frustration and a thinly veiled animosity for the perpetrators of this miserable crisis. This is obviously a legislature heavily influenced by the trial bar and the legal profession which is not necessarily very responsive or sympathetic. They have for decades effectively controlled the state of Florida, its institutions, banks, and numerous business and service organizations. There are substantiated reports that this control exists in all phases of government, and it is apparent even to the casual observer that the good old boy "supreme" court of our state is part and parcel of the system.

Enter into this arena the Florida Medical Association which is trying desperately to influence the infrastructure of impossible situations, vested interests, and an unbelievable snow job perpetrated by the media. To right the unrightable wrong, uttered by Don Quixote, is by comparison an easy, simple job. However in this quest there is no Dulcinea.

In the last 12 hours I have seen several committee chairmen, some of whom conceptually believe in our efforts and our cause in this area and have temporarily passed major significant legislation concerning our trauma network. This may be a cop out way of saying it probably won't pass, but let's be nice about it by consigning it to the limbo of unpassable bills. Committee structures in the Florida Legislature do this because of their inability or recalcitrance to handle the issue at hand; in this case limited liability for those doctors serving in the area of trauma networks and emergency room care. There is no real awareness of the blood, the death, the suffering and the split second decisions that mean the difference between life and death in an unconscious patient that each and every one of you has experienced at least on a few or perhaps hundreds of occasions throughout your career. This cannot and never will reach even the most remote corner of their conscious mind, and as a result they're incapable of reacting on even the most primitive level to your needs for survival in such an arena. If I sound a bit derogatory and cynical have no fear. Many of you and hardly any of them will read or acknowledge the thoughts and emotions expressed on this page.

Following this brief encounter, a meeting with the lieutenant governor, a dear friend, occurred. In this approximately 30-minute period most of the concern of our 15,000 members was expressed. Where are the other 7,000 who are in the wings and do not participate when we desperately need their financial, emotional and moral support? He heard our worries and fears and expressed in stated and unstated words thoughts which his high office had about the pragmatic politics of noncommitment and an adver-

sarial legislature which can shoot down any plans and programs of a new governor. The fact that some 8,000 of you may have no insurance or must pay for prior acts (tail) coverage of $20,000 to $150,000 or more because you have to change companies is of concern, but not too much!

We then had a briefing on a number of bills. These included Chiropractic Injections, Cleveland Clinic, Mandatory Acceptance of Assignment as a Condition of Licensure, a law that no profit could be made on medications dispensed by physicians in their offices; and on and on.

The not-for-profit bill is interesting in that occasionally physicians sell to patients at less than the wholesale price to druggists making a small profit. More often, they give the medication away at no charge to cover their expenses. This allows them at least to break even on the medications in question.

And, oh yes, the liability problems; the insurance crisis; the indigent care bill (actually four bills), the trauma bill (four bills), the insurance subsidization bill, and was it five or ten other bills equally seriously affecting medicine and how you practice on a day-to-day basis?

Heavens, it's 2:00 p.m., and we have a meeting with the insurance commissioner.

A plan!

It is a mandatory pool for all physicians to be required to carry $250,000 worth of insurance, paid for by the hospitals. There is no cap, or limits on them, just our awards. Truly, a plaintiff retirement fund!

It would be paid for by the hospitals and obviously passed on to affect the patient who has the outrageous misfortunate to be ill. The problem is that this cost is often paid for by elderly, retired people; the workers; the poor; the semi-indigent; the underinsured; or perhaps the noninsured.

No one in this group can afford, nor should they be required, to have this cost settled upon them as an indirect pass through from the hospitals. It's interesting that the Florida Consumer Federation supported the concept. But they are a puppet of the trial bar, so I suppose it's not surprising; however, if I were one of their members I would be upset.

The physician! He is handcuffed to the hospital, to the benevolent monarchy of administration, to the whims of an occasionally onerous edict. Perhaps this is never in the interest of quality care and the concerns of those entrusted with patients. The physician!

Under this proposal, the "State" will exercise total control over physicians and the lawyers will continue to sue. The physician! Oh, he will be free of that horribly high first $250,000 worth of liability premiums. But he might like it, until he has to buy the rest of his coverage at unconscionable cost. He will also have to be told he must conform. The state demands this and that and mandates what? Is it fees, assignment, revocation of license for a claim? The trade off!

The legislature never has to face up to the real culprit of the health care crisis, a lecherous, bloated money hungry, power happy trial bar which continues to protect rights!

Whose?

To the detriment of every citizen of this state, there will continue to be anxiety that every health care professional and doctor faces with every patient they see. The continued fear of defamation of character, of impugning ability. True, implications are that medicine is entirely socialized under the worst combination of collectivism as expressed by Marx, Lenin and even George Orwell.

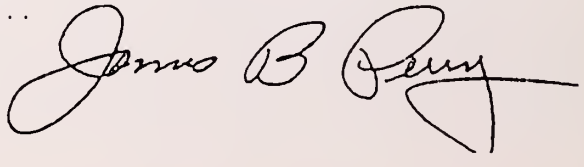
If we don't agree, our doctors have no insurance. Perhaps that would be good, let the state solve our problems. Perhaps we should have never, as responsible members of society and as a profession, helped them in 1975. Perhaps we should let the crisis develop and the people demand help. But to whom? They have been screaming for years to deaf ears or is it a cynical laissez faire group who cannot move because of the discord of the trial bar concerto that continues to drown out our voice of reason. Or shall we try, against all odds, to get the "captured insurance companies" to be the last of the free enterprise system still not for profit in the medical profession continuing to do business; but free! The decision: let it function and quickly. Get a plan ready and offer a solution. Solution? At what cost?

We do a lot of work overnight on the last idea as a responsible alternative.

By now it is 5 p.m., and we have dissected and pondered ways to circumvent the problems as expressed. A member of the Department of Professional Regulation staff comes in with a problem about double-dipping by some physicians visiting nursing homes. They send bills to patients and then bill (accepting assignment) for the same visit from Medicare. A felony!

It is time to run and catch a plane. Have to go home, try to rest, write this, be on a plane at 7 a.m., for Jacksonville for another meeting. This time it's about our insurance company. Can we expand, take 3,000 or 4,000 more members if St. Paul pulls out? Are we able to meet insurance company and state insurance department criteria? How can we be adversaries and at the same time need the help of the insurance commissioner, approaching him with hat in hand?

This isn't the job of a medical society president. This is a nightmare of hell. Our Father, who art in Heaven. . .Thy will be done on earth. . .and give us this day our daily bread. . .but deliver us from evil. . .for thine is the kingdom and power and the glory. . .



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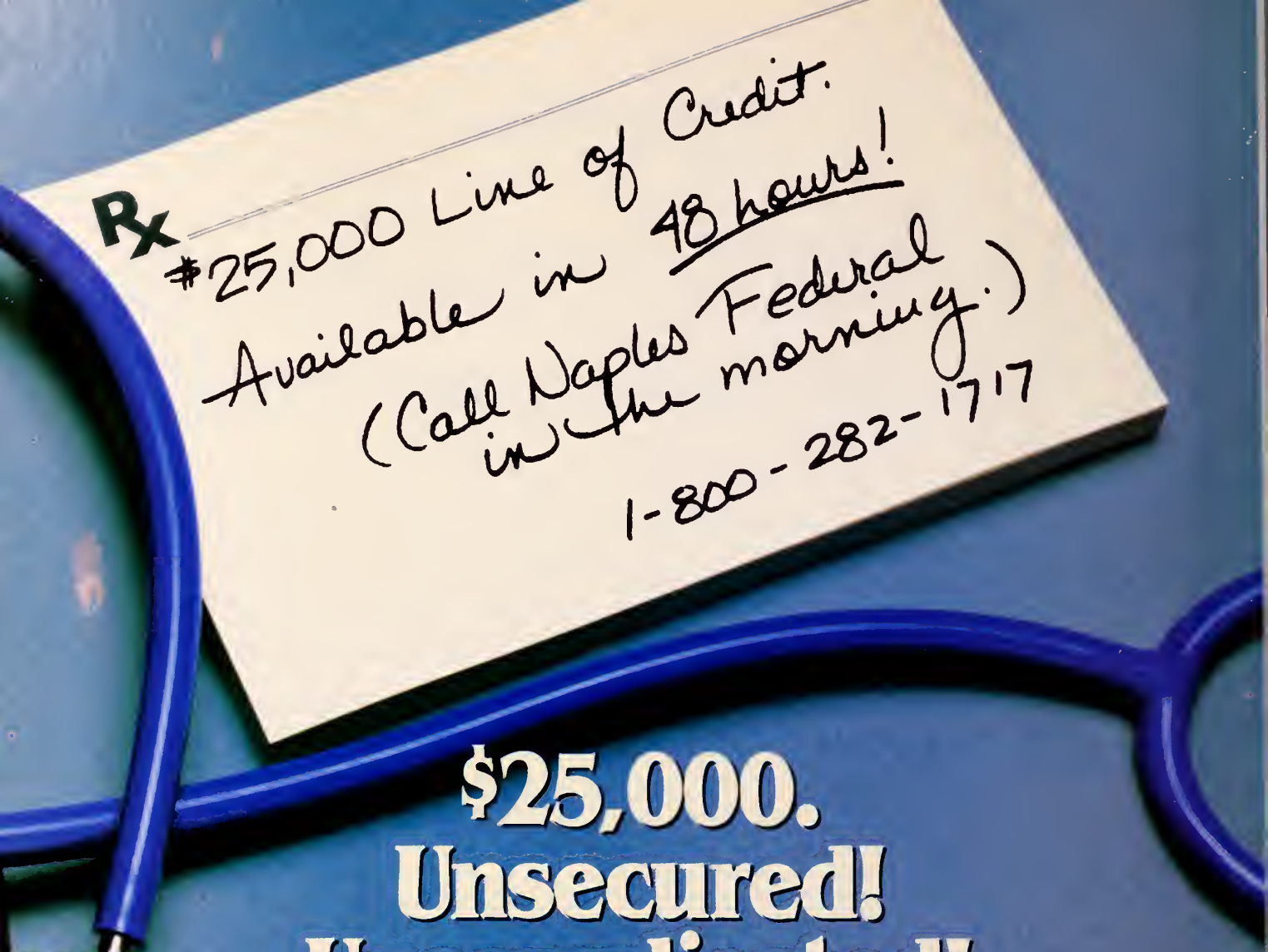
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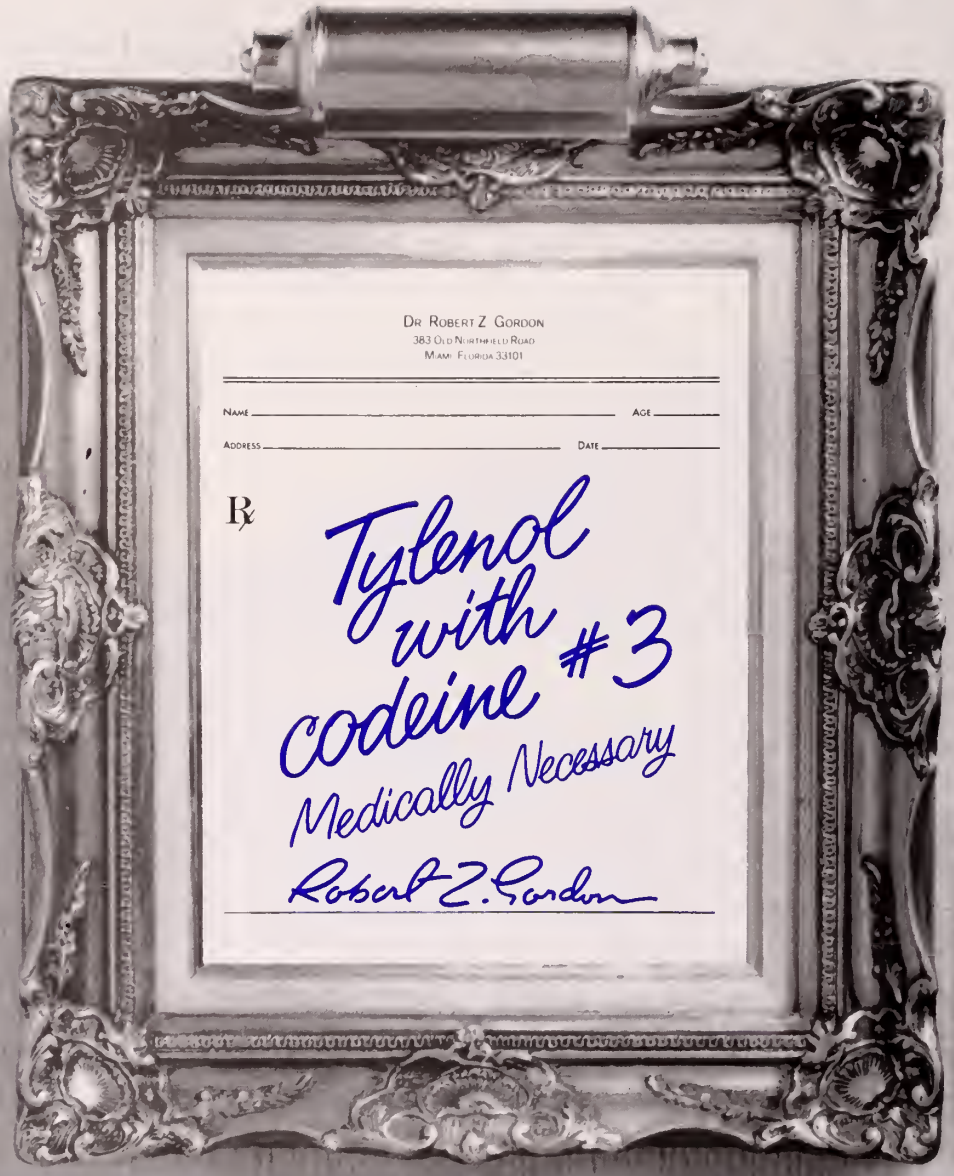
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Ethics and economics in medicine: a quandary

Americans today are talking a lot about ethics, or, more specifically, about the erosion of ethics in national life. There is a pervasive feeling that long-held values and standards that have been melded into the national fabric are crumbling and falling by the wayside. The daily fare on TV and in newspapers of Wall Street trading scandals, evangelical holy wars, adultery in high places, rampant misconduct in the administration, and public lying attests to the gravity of the problem. *TIME* magazine, in a recent cover story on the subject, spoke of the assault by sleaze, scandals and hyprocrisy on America's moral bearings. It is not a pretty scene.

The current ethical morass has not spared any segment of our society. What is frightening about the whole thing is that a lot of us have lost the capacity for moral outrage over the shenanigans that go on everyday. Skirting the law and bending the rules have become commonplace and accepted practices. Who cares if the next-door neighbor cheats on his income tax every year? Who cares about our favorite politician making deals to fatten the wallets of his friends? And who gives a damn about a colleague who earns an extra $12,000 every year by overutilizing services and procedure? As if this assault into our values and ethical standards is not enough, we appear to exalt the wrongdoers by making them best-selling authors, television heroes, or highly paid lecturers. This is perversion of the worst kind that already has undermined the ethical moorings of our society.

Medicine is not yet plagued by the kind of scandals that have infected politics, business, popular religion, and many other professions. But we ought to watch out. The same forces that are driving these enterprises are now operating in medicine. Many ethical dilemmas now confronting physicians are of recent vintage, evolving from developments that have transformed medicine from a purely healing profession into a gargantuan business enterprise. These dilemmas involving the economic interests of physicians potentially pose the biggest problem for the medical profession.

The increasing emphasis on the business aspects of medicine has been spurred by the introduction of competition in medical care. Along with this, changes in the reimbursement system by Medicare, the entrance of corporations into the world of medicine, and an increasing supply of physicians have put pressures on physicians to abandon traditional practices and to position themselves economically. As a result, many physicians have joined HMOs and other similar organizations, opened ambulatory clinics, participated in joint ventures with hospitals, operated x-ray and diagnostic clinics, and even started dispensing drugs in their offices. The emergence of the physician-entrepreneur has become the centerpiece of a raging debate: how ethical is it for physicians to practice their profession with potential conflicts of interest?

The debate is intense not only among physicians but outside the profession as well. Many physicians are justifiably disturbed by what they see because medicine has long been steeped in a solid tradition of ethics that is now threatened by economic imperatives. From the Hippocratic oath to modern-day principles of ethics, the emphasis is on the interests of the patient. Critics of the physician-entrepreneurs are charging that the pocketbook issue may take precedence and that even honest decisions may be tainted by hints of profiteering. The question is often asked: What is to prevent a physician from making clinical decisions that are economically advantageous to him?

Most physicians, of course, are honest, and

will maintain that owning a piece of the action is not all that bad, that the conflicts of interests are no more than those involved in the private practice of medicine, and that certain endeavors—the dispensing of drugs by physicians in their offices, for example—works for the benefit of their patients. Even granting these arguments, a lot of skepticism still remains. A number of state legislatures have introduced bills requiring physicians with interests in medical facilities to disclose their ownership in such ventures, and in a few cases to prohibit physicians from referring their own patients to these facilities. Even Congress this year has toyed seriously with the idea of banning drug dispensing by physicians. The conflicts-of-interests issue will not die down easily.

Few physicians will be gnashing their teeth over these ethical quandaries if the medical profession were not bound by such high standards, standards more demanding than any other profession. And therein lies the challenge for all physicians. Medicine owes its high public esteem to its code of ethics; in grappling with current economic realities, physicians must be steadfast at the same time adhering to their high ethical standards. It is a difficult balancing act, but physicians must take care that they don't fall down in the process.

R. G. Lacsamana, M.D.
Editor

Contrasting perspectives on the malpractice problem

When the reader reads this editorial the Legislature will already have adjourned and we will all know what action has been taken on malpractice. As I write this, the Legislature is in its final week and for all intents and purposes the only bill concerning malpractice is the Ogden bill which calls for a madatory insurance pool. The Barron bill, which provided for a compensation plan outside the tort system, is dead. This bill apparently had no chance in the House and died recently. Whether or not the Ogden bill is the law of the state when this is written remains uncertain.

What is certain is that the Legislature and the physicians of the state have very little common ground on which to arrive at a satisfactory solution. This has become clear over the past two months as I have talked with and listened to legislators, leaders of the FMA, physicians and citizens. The Legislature and the physicians simply view the malpractice crisis from entirely different perspectives and as long as the Legislature continues to look at the crisis from its present viewpoint, there will be no satisfactory solution acceptable to the physicians.

As physicians, we view the malpractice situation in several contexts. We are very concerned about the cost of our insurance premiums. This is very understandable to us, as the premiums have been on an upward spiral with no end in sight and in some cases now exceed 30 percent of physicians' incomes. This is a far cry from 3 to 4 percent of the gross income which trial attorneys claim we pay for malpractice and is an acceptable cost of "doing business." We view the malpractice situation in a very personal manner. It is disturbing to us that over one third of the physicians in this state will have to go through the anxiety and trauma of a lawsuit which disrupts not only medical practice, but also the personal life of the people involved. Lastly, we view the malpractice as a sociological and cultural problem which has destroyed the usual physician-patient relationship and turned what should be a very trusting and comfortable relationship into one of wariness, distrust and enmity.

On the other hand, the Legislature views malpractice from an entriely different perspective. First, the personal relationship of the physician-patient is something with which legislators are not concerned. It should be made clear that when I speak of the Legislature, I am speaking collectively. There are individual members who do not fit this categorization that I am making, but since the actions of the Legislature are done as a whole, I will continue to describe it in a collective vein. Perhaps, it is asking too much to expect a governing body to become involved in any profession-client relationship. The legislators probably feel that their charge does not and should not let that influence any decision involving that particular profession. The Legislature's concern with the cultural and sociological aspect of the problem is conducted on a broader scale than we physicians view the situation. The Legislature views the relationship as one of the patient being able to have access to a physician. This strips the cultural, sociological question down to the bare essentials. There are no frills. The only important ingredient is that a doctor is available to care for a patient. This may sound rather callous, but the goal of the Legislature and how its views the patient-doctor relationship differs greatly from our viewpoint.

Secondly, the Legislature has no need to be concerned about the personal feelings of physicians or the anxities produced by a lawsuit. The individual feelings of any citizen or a group of citizens is relatively unimportant because the greater good of the citizens as a collective whole is a paramount feature. Of course, what the Legislature considers to be good for the citizens may vary greatly from what physicians feel are good for the citizens.

All of the above differences between physicians and the Legislature are differences in perspective and, as such, represent different philosophical feelings and approaches to the problem. While these differences are serious, they are differences which physicians could probably accept if it were not for a more serious

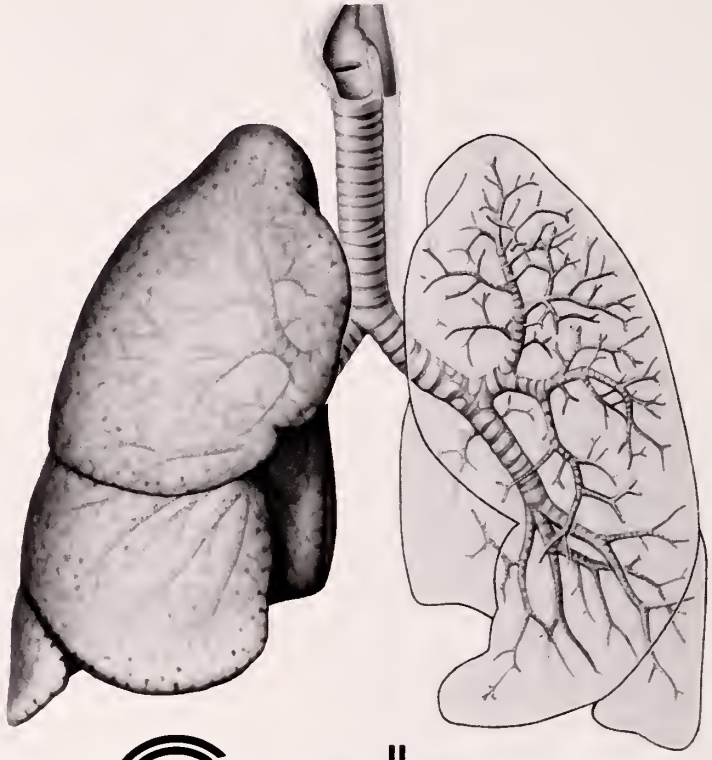
philosophical breach between the Legislature and physicians. These are, of course, the different viewpoints on the cost of malpractice insurance and its availability. We physicians view the cost of the rising premiums as being extremely important. The Legislature tends to minimize the cost of malpractice insurance as long as it is available. Now, the Legislature has said that it feels that the situation may be close to a crisis and there is talk of a special legislative session to address the malpractice crisis. However, it should be remembered this concern came only after two insurance companies threated to pull out of the state and leave 8,000 physicians without insurance. Suddenly, the Legislature and insurance commissioner were interested in seeing that insurance was available, at a price, they asserted, that was affordable, but I suspect that this was a secondary thought as they have shown very little interest in the price of malpractice insurance prior to this.

Of course, the question can be asked: If availability of funds to compensate patients for acts of malpractice or simply bad results in many cases is the most important ingredient in this whole affair, why should this not be done is a manner outside the tort system if it can accomplish the same purpose? The truth of the matter is that it is easier to establish a fund through the present tort system rather than take steps to establish a whole new concept, such as the Barron bill with its compensatory provisions outside the adversarial system. In order to do this, the Legislature would have to fight many battles with various interest groups such as some consumer groups and the trial attorneys. On the other hand, the Legislature can establish a means for maintaining an insurance pool under the present tort system and really only have to battle one specialty group—the physicians who represent a mere one percent of the population.

With these thoughts in mind, I have come to the conclusion that perhaps we would be better off if the Legislature did proceed with a state-sponsored insurance pool. I say this with difficulty, as I am against the Ogden plan and the only experience with state sponsored medical insurance has been the ill-conceived patient compensation plan, but at least this approach would answer some questions. If, by the grace of God, the plan would keep insurance premiums down, then we would know the insurance companies had been filling us with a line of blarney. On the other hand, if premiums were to continue to escalate and the state insurance plan was unable to stabilize premiums, then perhaps the Legislature would get a different perspective of the problem and realize the physicians may have had a valid point all along concerning the cost of malpractice insurance.

Frank Farmer, M.D., Ph.D.
New Smyrna Beach

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- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

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- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

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Tort reform critically needed

In light of the recent developments with two insurance companies leaving the state, the Supreme Court declaring unconstitutional provisions of tort reforms passed in 1986, and the escalating cost of malpractice insurance, I feel it is time for the Florida Medical Association to take some decisive and meaningful action to lead us in finding a solution to this crisis.

Three years ago we all contributed money to a fund to have a constitutional amendment put on the ballot for voters to make tort reform a part of the Florida constitution. In April or May of that year John Thrasher, the FMA attorney, visited the Clay County Medical Society meeting. At that time I questioned him as to why he felt the three-part proposal put together as one constitutional amendment for the ballot would stand up to Supreme Court scrutiny in view of the fact that only the year before the Florida Supreme Court had disallowed the placement of a three-part measure for tax limitation on the ballot. As I predicted to Mr. Thrasher, within a couple of months the Supreme Court declared the measure as presented to be out of line with the constitutional provision that only one item be voted on in each initiative measure on the ballot. The FMA's response to that was to drop the subject and apparently give up in attempting to have constitutional amendments passed by vote of the people to reform the tort system.

It is now time for the FMA and all its allies in the tort reform battle of 1986 to put their proposals for tort reform into the form of a series of individual constitutional amendments and get the necessary signatures to have each and every one of them placed on the ballot at the next general election. Only by having these items passed as constitutional amendments can we bypass the Florida Legislature which is seeded with lawyers that seek to sabotage the measures passed, and bypass the Florida Supreme Court which is obviously not sympathetic to the idea of reforming the tort system. The graduated schedule for lawyers' contingency fees should be made part of the state constitution so that no one can tamper with it in the future. A $250,000 cap on non-economic damages, commonly known as "pain and suffering" damages, should be made a part of the Florida constitution. This would bring our tort system into line with California and Indiana and several other states, whose measures have been found constitutional by the highest court of the land, the United States Supreme Court. Each and every one of the other measures that were proposed last year by the Alliance for Tort Reform should be put into the form of an individual constitutional amendment and voted into the constitution so that the legislature cannot tamper with it, even including those measures that were passed in whole or part by the legislature.

A crisis of confidence in the leadership of the Florida Medical Association, as demonstrated by its past failure to have these measures properly placed on the ballot for a vote to be made constitutional amendments, is now becoming more severe. Your prompt attention to this matter and vigorous leadership may yet save the day for Florida physicians and the entire system of health care in Florida. The time in now late, but because of the crisis atmosphere, proper leadership action may result in us finally achieving meaningful and lasting reform of the tort system which is the only possible way in which the malpractice liability insurance crisis can be brought under control. Do not try to limit those measures to medical malpractice, make them apply to all forms of lawsuits as the proposals in 1986 did.

Osbey L. Sayler, M.D., P.A.
Orange Park

More on tort reform

I received a letter in the mail today from Bill Gunter, State Treasurer and Insurance Commissioner. I was alarmed to learn that our legislators and representatives do not realize that we are shortly due for a very severe medical crisis.

The St. Paul Insurance Company insures 5,500 doctors in Florida and CIGNA (INA) insures 2,500 physicians in Florida. Both of these companies have elected not to renew medical malpractice policies. We estimate that in South Florida alone, beginning July 1, 1987, nearly 3,000 physicians will have no medical malpractice insurance policies. This is truly a crisis. In the state of Florida a physician cannot effectively practice by law without medical malpractice insurance. The state law says that if physicians do not carry a minimum of $250,000 in liability insurance, then they must have ready cold hard cash available to put into a trust fund in order to practice medicine. Most hospitals will not allow physicians on staff without malpractice insurance, even if they were to have that huge sum of money readily available, which I am sure most do not. This means that as of July 1, 1987, we will have a severe reduction in the ability of providing medical care to citizens of South Florida.

Legislators have been very remiss in enacting legislation to control the liability insurance problem. In fact, the Florida Supreme Court threw out a ruling for tort reform. This ruling for tort reform placed a very high cap of $450,000 strictly and only on non-economic damages for pain and suffering. There was no limitation for the award for economic damages, payment of losses from work for bills, etc. This decision by the Florida Supreme Court was arbitrary and extremely detrimental to our state since the insurance companies refuse to insure a state that has no lid on awards for non-economic purposes. In the state of California there has been a $250,000 cap on this award since 1985. The state of California has no medical crisis. There is more than adequate malpractice insurance for physicians and, in fact, the premiums for insurance are significantly lower in California than they are in Florida.

We acquired our independence as well as our tort system from England. However, England has progressed with the years and has done away with the tort system realizing its shortcomings. It is essential that Florida, like the rest of the country, enact reforms in tort law. This is essential because the pocketbook is not bottomless, and in the end we all suffer by our loss to provide for each other. Please share my concern with the public because the public must let our legislators know that they must be responsible to all of us. It is essential that 3,000 physicians do not go without medical malpractice coverage beginning July 1, 1987. Readers please send your letters to your legislators.

Thank you for your concern.

Linda J. Kaplan, M.D., F.A.A.O.
Hallandale

Editor's Comment: The FMA has spearheaded every battle for tort reform the past several years. It has succeeded in having some proposals passed in the state legislature but has been rebuffed at every turn by the Florida Supreme Court. A major professional liability crisis, as a consequence, is looming on the horizon.

Against this gathering storm, the FMA will continue to lead the fight for a permanent solution to the liability problem. As reported by FMA Vice-President Donald Jones in the May issue, the FMA will press for passage of the "Barron Plan" and also will continue to explore a consitutional initiative for tort refrom.

Rather than blame the FMA, Dr. Sayler should point a finger at the legislature and the state Supreme Court as the culprits responsible for the present liability crisis.

Defensive medicine defended

The editorial by Dr. Lacsamana, "Doing Less and Thinking More," April 1987, applauding Blue Cross-Blue Shield for denying reimbursement for "inappropriate" tests, states that defensive medicine is "indiscriminate testing," since "... it protects physicians more than it benefits its patients." If the physician does not protect himself, then he will not be able to practice long enough to benefit many patients.

I do not believe it is indiscriminate testing to perform those tests whose omission will expose a physician to civil or criminal liability.

Gilbert R. Panzer, M.D., P.A.
Boynton Beach

Editor's Comment: The absence of standards for diagnostic testing and the propensity to do an excessive number of tests and procedures, some of which may not be indicated, will not protect physicians from lawsuits. In fact, defensive medicine may make physicians more vulnerable targets. The availability of guidelines, on the other hand, spells out accepted standards of medical practice and will deter lawsuits as long as physicians adhere to those guidelines. Defensive medicine can be practiced prudently without resort to extensive testing.

Return to indemnity system?

Our whole wonderful system of tending the sick is foundering badly. What used to be a straightforward relationship between patient and doctor is now a more

and more confusing mess of financial finagling. Everybody keeps trying to find a happy solution that will pay doctors well, provide good care for patients, and keep the cost within reason. The government will provide the solution.

How did medical costs suddenly get so far out of kilter?

Thirty years ago, insurance coverage for doctor bills was largely limited to severe illness and surgery. You had to be in the hospital for it to pay and so the patients were coached to go in the hospital even when it was not clearly justifiable medically. The patient rationalized it that "I'm entitled to it because I've paid all that money in premiums."

Insurance coverage for doctor bills was entirely in indemnity form—if you had your appendix out, the payment to you for help on the doctor bills was $100 or $90 or more or less, depending on the size of your premiums. The exposure for the insurance company was highly predictable.

With the inception of Medicare the simple indemnity method was by-passed. The Congress wanted a system in which "every Medicare patient would have equal access to the very best medical care." So an elaborate method, made possible only by the availability of computers, was set up to pay doctors fees on a composite basis of Usual, Customary, and Reasonable (UCR). Provision was made for profiling each specialty, in each part of the country, and then individual physician's fees were profiled, and from all this data, the computer would determine what each doctor was "allowed" for each procedure.

Thus, a specialty that tended to fees producing a higher income was allowed more income than others. Thus, if fees were generally higher in one area than another, the doctors of that area were permitted higher "allowances" for the same work. And thus, also, if I set my fees higher than my competitor down the street, I am permitted higher "allowances" if my fees are within "Customary" range.

Unfair, on the face of it, of course. But, faced with inevitability of passage of Medicare, this UCR provision was included in the Medicare bill because the medical profession lobbied vigorously for it. But this profile system included a provision for annual recalculation of these allowances. So when a large number of doctors made substantial increases in their fees to the patients, this required revision upward of the "Customary" allowances. Over the years these "Customary" allowance have accordingly had to go up, sometimes in almost geometric progression, because such increase was mandated in the original Medicare bill.

Doctors being human beings, it was predictable (and predicted) that health care costs would greatly outrun the estimates.

And unless the government continues to mandate the fee freeze, the same human element will continue to operate to push fees even higher.

Amid all the gimmicks of HMOs, PPOs, IPAs, capitation, etc., etc., why do we never hear the word "indemnity" anymore? For years, that word was omitted from public discussion. Instead of all these complicated, confusing, and unpredictable approaches to the problem of third party payment, why don't we propose an indemnity allowance based on a national Relative Value Scale that will apply to all Medicare patients and all doctors in the country?

It could be uniform for the whole country (which might resolve some of the problems of physician distribution), or regional. It would provide that payment would go directly to doctors who agreed to accept it as full payment or substantial percentage of it. If the doctor did not accept assignment the reimbursement would go to the patient and the doctor would set his fees at whatever he thinks he can collect and still have patients.

This puts the doctor-patient relationship back to the old one to one market contract that always works. And this provides an ultimately simple method of keeping Medicare payment to doctors from continuing to escalate.

This would result in a much more effective relationship between doctor and patient.

There has evidently been a reluctance on the part of physician leaders to set up such "fee schedules" because of the threat that such schedules might be mandated as maximum limits for fees. And this has already happened in Massachusetts. But this is so foreign to the American way that it seems unlikely to prevail. On the face of it, the destructive effect on the quality of people being attracted to the practice of medicine would obviously downgrade the profesion with lesser quality health care providers.

So it seems like a chance worth taking. An indemnity system would finally give the government a solid handle on Medicare outlay for fees, without doing major damage to our present quality medical care.

W. E. Manry Jr., M.D.
Lake Wales

Florida medical care faces crisis

The nation's delivery system for medical care is in revolution, and in Florida it is a crisis. The cost of providing medical care is making it inaccessible for all but the wealthy and heavily insured.

Even the insurance companies are now realizing that there is a limit to what consumers are able to pay and are placing more and more restrictions on those providing care and demanding economy measures that severely affect the quality of care physicians can offer.

Improvements in health care in the last few years have made medicine in the United States the most advanced in the world and have exceeded our greatest expectations of 20 years ago. Smallpox, polio, and

many other contagious diseases have been virtually wiped out.

Less than 50 miles from Palatka, in addition to many kidney replacements and other organ transplants, over 20 heart replacements have been carried out with amazing success.

Improvements in technology and diagnostic instruments are turning medicine more and more into a science and less of an art. It is unfortunate that the ability to deliver superior health care is being severely limited, and even endangered, because of Florida's tort system that declares open season on family physicians and surgeons.

The government, rather than addressing the tort system regarding malpractice suits which drives the cost of delivering medical services continually upward, has chosen to hack away at the costs of patient care by curtailing desirable services.

Government regulations, dictated out of Washington, enforced and regulated by a State PRO from Tampa with surveillance teams in practically every hospital in Florida, are primarily interested in cutting costs. Following their rules and dictates can cut costs but it makes the delivery of quality care very frustrating and places the attending physician in constant jeopardy from a litigious society demanding only the best of care. The cost of this surveillance system is another tremendous cost to the patient.

Because of the demand for "no-error medicine," doctors need liability insurance for their protection and the protection of their patients. No doctor can guarantee a successful outcome for every patient, nor is he ever perfect.

According to Insurance Commissioner Bill Gunter, Florida is again in a health care crisis due to the unavailability, or unaffordability, of liability insurance for doctors. Many are refusing to risk their total family assets in emergency situations where they are required to attend high risk patients, frequently for no remuneration.

The last remaining commercial insurance company writing liability insurance for surgeons and obstetricians in Florida (St. Paul's) has sent out notices to over 5,000 doctors advising that it will no longer insure physicians in Florida. All others left the state last year after the Florida Legislature failed to adequately address the problem.

Last month the Florida Supreme Court struck down, for the third time in seven years, even those little measures which could have offered minimal relief. The first time, in 1980, the court declared unconstitutional the mediation panels which were working so well in Florida and which were actually bringing rates down. These medication panels continue to work well in other areas.

The second time the Supreme Court struck was in 1985 when the Florida Medical Association tried to get a constitutional amendment on the ballot to bring about some limitations on lawsuits.

One Palatka doctor's early retirement last year was primarily due to the above two problems. Another left last month to practice in another state where he will save thousands of dollars each year in insurance costs. At this moment several other local doctors are seriously considering leaving the state. When St. Paul's pulls out of Florida on July 1, 1987, 16 physicians practicing in Putnam County will have no liability insurance.

Trying to recruit good new doctors to a state where liability insurance is either the highest in the United States, or unavailable, is difficult.

Most hospitals require their doctors to have insurance coverage. Fortunately Putnam Community Hospital does not. If it did, Putnam County would soon have no obstetrical services and even fewer doctors.

For the past two years the Florida Legislature's Band-aid approach to a hemorrhaging condition has aggravated the situation. The result is annual increased insurance rates above 30 percent and amounting to thousands of dollars each month.

Again this year the same tactic is being used by the lawyer dominated Legislature. Several bills now pending will again only serve to further aggravate the situation.

The real problem is the tort system which allows an irreverent breed of lawyer to seek out clients to file suits against their physicians, and the willingness of emotional juries to award extortionate sums in many cases. This drives up everyone's insurance costs.

Unless this problem is adequately addressed immediately, medical malpractice should be removed from the tort system. Doctors cannot continue to put their lives and livelihood on the line with every treatment of a patient. Many are simply quitting practice in utter frustration.

There is no simple solution, but other states are bringing the problem under control. Only in Florida have our lawmakers failed to addresss this issue that affects almost all citizens in increased costs. And, unfortunately, it worsens each year.

Left to the machinations of the Legislature, health care in Florida is in grave danger. Putnam County is no exception. Doctors here, and throughout Florida, have made many attempts to correct the situation without success. There is no recourse but to pass along the high cost of insurance premiums to patients. Neither the doctors nor the public can continue this spiral; however, it seems apparent the Florida Legislature will do nothing of a positive nature until the public gets angry enough to rebel.

Roy E. Campbell, M.D.
Palatka

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Motorboat propeller injuries

Charles T. Price, M.D., and Charles W. Moorefield, M.D.

ABSTRACT: Boat propeller injuries are often severe and disfiguring. Two hundred seven members of the Florida Orthopedic Society responded to a survey and identified 195 boat propeller injuries from 1979 to 1983. This number vastly exceeds the 30 cases reported to the United States Department of Transportation during the same five year period. Waterskiing accounts for most injuries. The 11-20 year age group is at greatest risk. Our experience suggests the need for better regulations and enforcement. Consideration should be given to developing propeller guards as a preventive measure.

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Boat propeller injuries, if not fatal, are usually severe and disfiguring resulting in prolonged disability and permanent impairment requiring costly medical, surgical and rehabilitative services.[1-4] The purpose of this paper is to again call attention to this problem, to point out that the true incidence of propeller injuries is much higher than reported, and to suggest that current safe boating practices or regulations have not been effective in stemming the number of these accidents.

Case reports, Department of Transportation accident reports, and a survey of members of the Florida Orthopedic Society were used to assess the incidence, severity, and risk factors associated with propeller injuries.

Case reports • Case 1—The first case involves a 17-year-old female who fell from the stern of a 20-foot motorboat and was struck by the propeller injuring her right leg (Fig. 1). She sustained multiple lacerations of the right knee, posterior calf and heel. Her wounds were debrided and closed and healed without complications. Most reported cases do not have such favorable outcome.

Case 2—The second case is that of a 29-year-old woman who was in a canoe with her husband and 8-year-old daughter when they were struck broadside by a 17-foot ski boat. She sustained the following injuries: extensive laceration of the right thigh, open fracture of the right pubis, laceration of the femoral vessels, compound fractures of the left tibia and fibula, open injuries to the left foot, right ear, and scalp with subarachnoid hemorrhage. She was pronounced dead on arrival at the hospital with the cause of death being blood loss from laceration of the femoral vessel (Fig. 2).



Fig. 1.—Seventeen-year-old female struck by propeller on leg.

Department of Transportation records • The true incidence of these accidents is difficult to assess.[5-9] The current regulations of the United States Department of Transportation require that any recreational vessel involved in an accident file a report if there is: (1) loss of life, (2) personal injury requiring medical treatment beyond first aid, (3) damage to the vessel and other property exceeding $200, or (4) complete loss of the vessel. As pointed out in the yearly report, analysis of nonfatal accidents is difficult because of the following reasons: (1) some accidents are of a small enough magnitude that they are not required to be reported, (2) some are not reported because of ignorance of the law and difficulty enforcing it, and (3) federal regulations do not require accident reports in states without boat numbering systems or in private waters where there is no jurisdiction. In fact, the Coast Guard estimates that only 5% to 10% of reportable accidents not causing fatalities actually come to their attention. During the five-year period included in our survey, less than 30 propeller injuries were reported to officials in the State of Florida.[5-9]

Florida Orthopedic Society survey • In an effort to determine the incidence of these accidents a postcard survey was conducted with the members of the Florida Orthopedic Society. Two hundred seven of the 398 members responded, approximately 50%. In addition to the number of propeller injuries seen, the survey requested information regarding the situations surrounding the accidents, ages of the victims, and types of trauma sustained.

A total of 305 propeller injuries were discovered from the survery. One hundred ninety five occurred in the five-year designated period, 1979 to 1983. The highest incidence was seen in the 11-20 year age group with the majority of patients being between 11-40 years of age (Fig. 3). Waterskiing was the activity most often associated with propeller injuries accounting for 93 (48%) of the cases (Table 1). Falls from boats were next in frequency resulting in 70 (36%) of the accidents. The percentage drops sharply after this with 18 injuries (9%) attributed to swimming, three (1.5%) each related to scuba diving and airboating. Eight patients were grouped into a miscellaneous category with their propeller injuries being due to uncommon causes such as collisions.



Fig. 2.—Twenty-nine-year old female struck on leg, groin and head.

The severity of the trauma covered a broad spectrum from superficial lacerations to death. The most ofter reported injuries were lacerations, ranging from simple to multiple; massive, deep wounds; open fractures and amputation. There were five deaths.

Comment • Based on this survey of the Florida Orthopedic Society, the true incidence of boat propeller injuries in the State of Florida vastly exceeds the number reported. This is supported by the United States Department of Transportation which estimates that reports are received on only 5-10% of nonfatal reportable accidents.[5-9] Indeed, in the five-year period when less than 30 propeller injuries were reported in Florida, 207 members of the Florida Orthopedic Society alone saw 195 propeller injuries.

Boat propeller injuries, if not fatal, often lead to severe, permanent disability and disfigurement. The

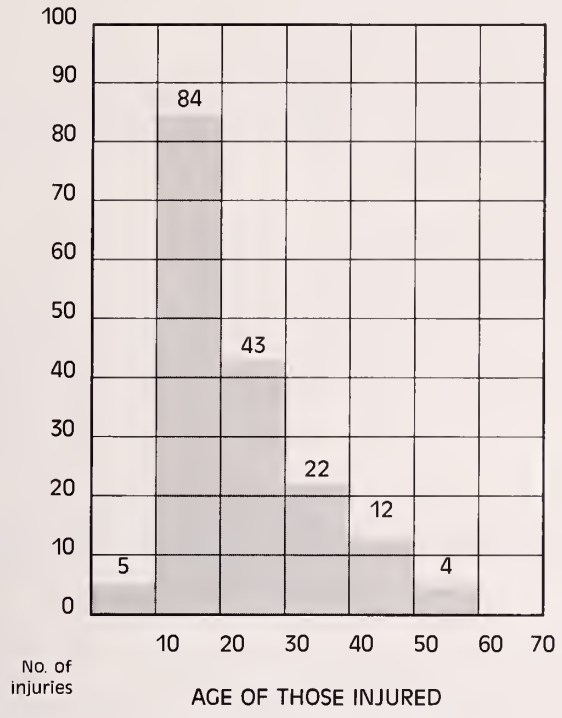


Fig. 3.—Incidence of propeller injuries by age.

Table 1.—Activities Associated with Propeller Injuries.

CAUSE OF INJURY	NUMBER	PERCENT
Waterskiing	93	48
Falling from boat	70	36
Swimming	18	9
Scuba diving	3	1.5
Airboats	3	1.5
Miscellaneous	8	4

majority of accidents occur in the 11-40 year age group with the highest likelihood being in patients from 11-20 years of age. Waterskiing is the activity most often associated with propeller injuries followed closely by falls from boats.

Some communities do not have boating safety regulations. Even when boating laws exist[10] propeller injuries have still occurred. Stricter enforcement of existing boating laws such as requiring a mirror or spotter while waterskiing should be encouraged. This includes enforcement of laws governing boat operation while intoxicated. Consideration should be given to age and proficiency requirements for licensing boat operators. We believe that measures such as these would reduce the total number of boating accidents.

We have made several attempts to meet with boating manufacturers to discuss safety modifications. These efforts were met with either resistance or reluctance on the part of boating representatives to get involved.

Specifically for propeller injuries, boat engine manufacturers should investigate the possible development of propeller guards to reduce the toll of these severe injuries.

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Palliative balloon valvuloplasty for calcific aortic stenosis in the elderly

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ABSTRACT: A 72-year-old man with rectal carcinoma presented with signs and symptoms of severe calcific aortic stenosis. To diminish the risk from rectal surgery, balloon valvuloplasty was performed which reduced the aortic valve gradient from 80 to 35 mm Hg and increased the valve area from 0.8 to 1.1 cm. The procedure was well tolerated and without short-term complication. Balloon valvuloplasty provides a new therapeutic alternative to aortic value replacement in selected patients with calcific aortic stenosis.

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Use of balloon dilatation catheters has revolutionized treatment of obstructive coronary artery disease since development of percutaneous transluminal coronary angioplasty (PTCA) in the late 1970s. This technique has become the procedure of choice in many patients as primary interventional therapy and an increasing number of patients are being treated with PTCA for palliative reasons. Recently use of balloon catheters has been expanded to stenotic cardiac valves.

In the adult population the most common stenotic valvular lesion is aortic stenosis. It is known that once symptoms occur with this lesion, the prognosis is poor and aortic valve replacement improves both symptoms and survival.[1] Aortic stenosis most commonly occurs in older patients where the incidence of other systemic illnesses which limit life expectancy increases. Thus the clinician is often faced with the problem of the patient with aortic stenosis needing surgery for palliation of symptoms who is less likely to benefit from life prolonging benefits of the procedure because of age and associated illness. With the large number of elderly patients residing in Florida, this becomes a frequent and important problem. This case is presented to illustrate a new option that balloon valvuloplasty offers both physician and patient in this circumstance.

Case report • A 72-year-old man was transferred to our hospital for evaluation of rectal bleeding. He had bleeding one to two times per week for approximately four months until several weeks prior to admission when it became a daily occurrence. Over this time he experienced a 20 pound weight loss and two episodes of syncope with increasing weakness and dizziness. His past medical history was remarkable for hypertension treated with hydrochlorothiazide, inter-

mittent atrial fibrillation controlled with digoxin and a five-year history of exertional angina treated with topical nitrates and diltiazem. He had a murmur diagnosed as aortic stenosis for years. On admission to another area hospital, the hemoglobin was 8.3 grams and after transfusion with three units of packed red blood cells he was transferred for further evaluation.

Physical examination revealed blood pressure 160/70 mg Hg and regular pulse rate of 72 beats per minute. The remainder of the physical examination was remarkable only for a grade 3/6 mid to late peaking systolic ejection murmur at the base which radiated to the neck and a decreased aortic component of the second heart sound. The carotid pulses were normal.

Lower gastrointestinal evaluation revealed a 15 cm moderately differentiated adenocarcinoma of the rectum without apparent metastases. A 2-dimensional echocardiogram with Doppler interrogation revealed a calcific aortic valve with a peak systolic gradient of 80 mg Hg and symmetric left ventricular hypertrophy. Cardiac catheterization confirmed severe aortic stenosis without aortic insufficiency and no other pressure gradients. The hemodynamic findings are summarized in Table 1. In addition there were two areas of 60% stenosis in the left circumflex coronary artery.

Because of the severity of aortic stenosis, we believed the patient was at increased risk for the necessary rectal surgery. It was decided to perform valvuloplasty of the aortic valve as a palliative procedure. Endocarditis prophylaxis was started. Using the right brachial approach, venous and arterial catheters were placed in the ascending aorta and pulmonary artery for pressure monitoring. The patient was heparinized. The left femoral artery was isolated by cutdown and a #8 pigtail catheter and a .035" guide wire was placed into the left ventricle retrograde across the aortic valve. Using an exchange technique, a 12 mm Meditech® balloon dilatation catheter was placed across the aortic valve and inflated to 3.4 atmospheres for several seconds revealing an indentation in the balloon in the region where it crossed the stenotic valve. After one inflation, the inflated balloon moved freely across the valve and no further indentation was present. The balloon was replaced with a 20 mm balloon and the process repeated (Fig. 1). The aortic valve gradient and cardiac output were measured and the area calculated (Fig. 2). Ascending aortic

Table 1.—Hemodynamic Values Prior to Valvuloplasty.

Heart Rate	62 BPM
Right Atrium	(3)*
Right Ventricle	40/4
Pulmonary Artery	40/10 (18)
Pulmonary Artery Wedge	(12)
Left Ventricle	250/20
Aorta	180/58 (94)
Cardiac Output	6.8 liters/min

*All pressures in mm Hg (mean)

BPM = beats per minute

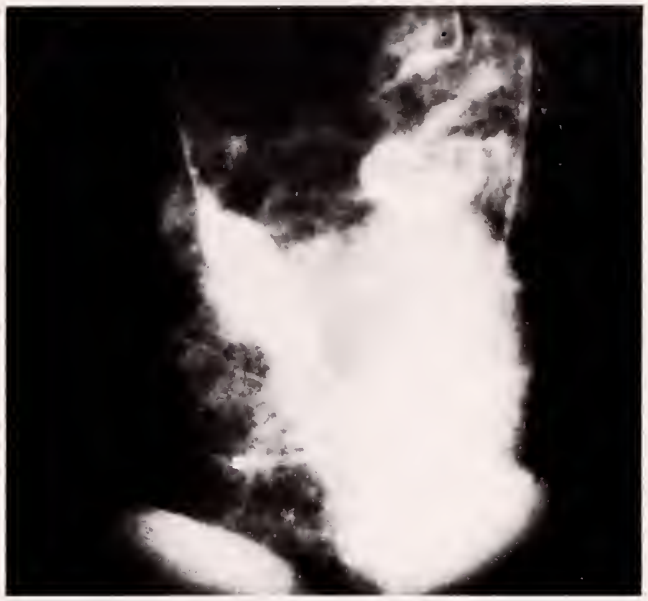


Fig. 1. — Left anterior oblique view of inflated balloon across the aortic valve. Slight dimpling of balloon is present in the area of the stenotic valve.

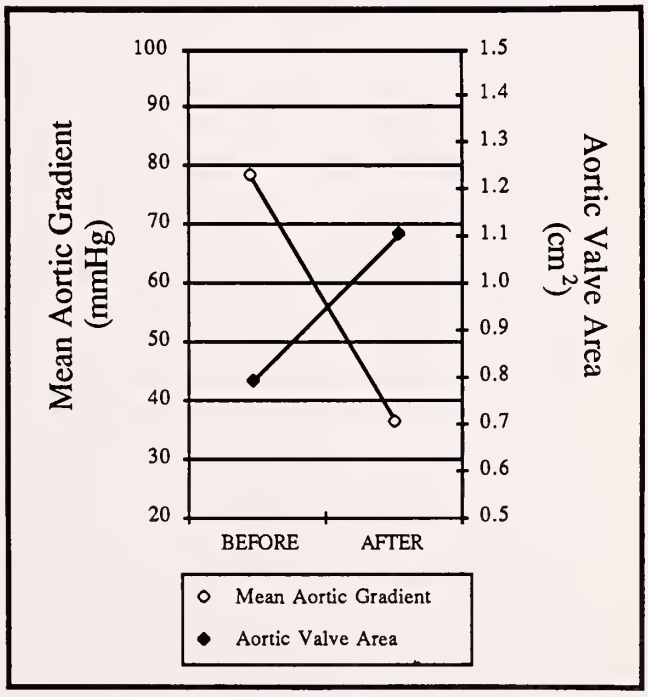


Fig. 2.—Change in aortic valve mean gradient (open squares) and mean area (closed squares) after balloon valvuloplasty.

angiography showed no aortic insufficiency. The patient tolerated the procedure well without symptoms, significant arrhythmias or hemodynamic deterioration. His postvalvuloplasty course was uneventful. Doppler interrogation one week later showed an estimated aortic value gradient of 36 mm Hg.

Discussion ● Balloon dilatation of stenotic cardiac values was first reported in pulmonic stenosis in 1982[2] and aortic stenosis in 1984,[3] both from experience in children. Our group first reported successful dilatation of the pulmonic valve in an adult in 1982,[4] and this procedure has evolved into a reasonable alternative to surgery in many patients with pulmonic stenosis. Primarily because of fear of systemic embolization and excellent results with valve replacement, dilatation of calcific left-sided valves in adults was not attempted initially. Very recently, McKay[5] and Palacios[6] in separate reports presented two cases of successful dilatation of the mitral valve in patients with calcific mitral stenosis. More recently, three preliminary studies of aortic valve dilatation have been reported.[7-9] These patients were generally quite ill, had been turned down for surgery or had refused aortic valve replacement. Combining these reports, 183 patients were studied at 18 centers. It appears that there were 16 deaths possibly related to the procedure but there was only one reported cerebral embolus. Aortic valve gradients were generally decreased by approximately 50% and valve areas increased into the range of 0.8-1.0 cm.[2] This is similar to the values achieved in the present case. It appears from these preliminary reports that balloon aortic valvuloplasty is a reasonable short-term alternative to valve replacement.

While aortic valve replacement can be performed with good results in elderly patients, it is not without complications. A recent report[1] of 50 patients over 70 years of age with aortic valve replacement showed a 60% five-year survival but a 14% hospital mortality. In addition, there was a 33% incidence of tachyarrhythmias, 21% incidence of chest infection, 7% incidence of heart block, and assorted other complications. Another study of aortic valve replacement,[10] although not exclusively in the elderly, demonstrated a rate of thromboembolic complications of up to 10%/patient-year in patients with mechanical valves. When a high percentage of patients are chronically anticoagulated, this rate is substantially reduced (2.5%/patient-year) but not eliminated. The exact incidence of complications related to chronic anticoagulation therapy varies among studies, but the need for this type of treatment adds to the risks and costs incurred. There is no reason for the patient undergoing aortic balloon valvuloplasty to require long-term anticoagulation.

Numerous questions still remain regarding the appropriate use of this technique. These include: (1) How large a balloon should be used? (2) How much should the operator attempt to reduce the aortic valve gradient? (3) Will restenosis occur and how quickly? and (4) What is the role for prophylactic dilatation in asymptomatic patients? How these and other questions are eventually addressed will dictate the future of balloon dilatation for calcific aortic stenosis.

Conclusions ● The potential role, appropriate patient selection criteria, and various technical questions regarding balloon valvuloplasty remain to be determined. At this time, long-term follow-up information is not available. If proven to be safe and effective, the inherent risks of valve replacement, subsequent anticoagulation and potential for valve failure may be delayed or eliminated using this technique as an alternative therapy. While it does not appear that valve dilatation will replace valve surgery, especially for regurgitant lesions, the potential exists for substantial cost saving and reduction in morbidity using dilatation in selected cases.

Addendum

The patient underwent uncomplicated abdominal-perineal resection of his rectal cancer and on follow-up six months later had no cardiac symptoms.

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Peritonitis frequency in CAPD patients

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ABSTRACT: We observed a high overall rate of peritonitis in CAPD patients treated at a single center. To investigate this finding we analyzed our highest and lowest peritonitis frequency patients in an effort to find factors which might help identify those at increased risk. Significant work experience was the factor most frequently associated with a low rate of peritonitis. Youth, public assistance, and public housing were associated with high rates as were criminal record, substance abuse, and psychiatric problems. The success and cost of CAPD programs will in part depend on local patient demographics and cannot necessarily be inferred from regional or national registries.

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Peritoneal dialysis has become a well established technique in recent years and is now widely available for patients with chronic renal failure. More than 10% of American dialysis patients now use this method and the percentage continues to grow. Enthusiasm for this technique has been tempered by the continuing problem of peritonitis. While many episodes of peritonitis can be successfully managed with minimal morbidity on an outpatient basis, each episode is potentially hazardous to the patient, expensive, and may cause loss of some of the peritoneal filtering surface. Recurrent episodes can contribute to the high patient drop-out rate, which is about 50% after three years of CAPD.[1] The experience of pioneering centers such as the University of Toronto suggests that peritonitis rates can be held as low as one episode per 14.1 patient months. However, results obtained from a three-year review of the American National CAPD Registry revealed an overall rate of 1.7 episodes per 12 patient months.[2] Until further technical improvements can substantially reduce the risk of peritonitis, attention to patient selection will remain an important way of controlling the morbidity and expense of frequent episodes of peritonitis. We have reviewed patients treated at a single center in an effort to identify factors associated with high and low rates of peritonitis.

Methods • We arbitrarily defined a low rate of peritonitis as one episode per 9.5 months and a high rate as one episode per 2.5 months. We identified 17 patients having a low rate and 17 having a high rate from a total population of 62 patients. (Table 1) The two groups were closely matched for age, sex, race, and etiology of renal failure. We reviewed the dialysis experience of each group and we then evaluated each group for the following parameters: income, housing,

work experience, education, church affiliation, criminal record, substance abuse, and history of psychiatric referral. (Tables 2 and 3) We chose these factors because we had previously found them to be useful in assessing risk for dialysis morbidity. Significance assessment was performed by the chi-square method.

Table 1.—Patient Characteristics.

	Low Rate of Peritonitis One episode per 9.5 months	High Rate of Peritonitis One episode per 2.5 months
n=	17	17
Mean Age	46	42
Male	11	11
Female	6	6
Race:		
White	10	7
Black	7	10

Table 2.—Dialysis Experience.

	Low Rate of Peritonitis	High Rate of Peritonitis
Duration of CAPD	33 months	11 months
Annual Drop-Out Rate	1.8%	71%
Time to First Peritonitis Episode	70 weeks	8 weeks
Peritonitis Related Days of Hospitalization	33 (12 days/year)	101 (210 days/year)
Non-Peritonitis Related Days of Hospitalization	186 (67 days/year)	193 (210 days/year)
Total Yearly Days of Hospitalization Per Patient	12.9	17.3

The most striking association with a low rate of peritonitis was a history of steady employment. Living in public housing and receiving public assistance were both significant associations with a high rate of peritonitis. It is not yet clear whether public housing and public assistance are simply other markers of unemployment or are also acting independently to increase risk.

Table 3.—Factor Analysis.

	Low Rate of Peritonitis		High Rate of Peritonitis	
Income				
Receives Public Assistance	(3)	18%	(13)	76%*
No Public Assistance	(14)	82%	(4)	24%*
Housing				
Owns Own Home	(14)	82%	(2)	12%*
Rents or Public Housing	(3)	18%	(15)	88%*
Work Experience				
2 Years or Longer at Same Job	(16)	94%	(6)	35%*
Age				
30 Years or Less	(1)	6%	(9)	53%
Education				
High School Graduate	(10)	59%	(4)	24%
Active Church Affiliation	(13)	76%	(5)	29%
Criminal Record with Incarceration	(0)		(5)	30%
Alcohol or Drug Abuse	(0)		(7)	41%
History of Psychiatric Referral	(0)		(9)	47%

*$p < .01$

Discussion • Except for a high overall rate of peritonitis, the dialysis experience of our patients is not different than generally reported and in particular the days of hospitalization are quite similar to other published data.[2-4] We became interested in analysis of peritonitis when, as noted in Table 4, we did not observe a continuing downward trend in overall peritonitis frequency over time. The technique is not so complex that a lengthy "learning curve" would be expected, and in addition some of our earliest patients had very low rates of peritonitis—suggesting that patient selection might be a key determinant of frequency. Success with peritoneal dialysis requires motivation, responsibility, acquisition and maintenance of good technique, and a clean environment. Either the patient or the patient's family must be able to meet these requirements which define the same sort of social competence needed to acquire and hold a job.

Significant drug abuse, criminal activity and psychiatric illness were not found in our low risk group. These factors are more common in the indigent setting and their potential independent roles will also require further investigation.

These points, while perhaps intuitive, are not trivial. Misapplication of peritoneal dialysis may result in increased morbidity as well as greatly increased expense. Our data suggest that increased rates of peritonitis occur in young patients who lack significant work experience and are concentrated in public housing, receiving public assistance. If this indigent patient population is at increased risk for morbidity, then peritoneal dialysis may not be as favorable an option for them. Before reaching that conclusion, however, it will be necessary to compare a similar group's hemodialysis morbidity and expense, and to further assess the independent impact of the other fac-

Table 4.—Frequency of Peritonitis Episodes, 1981-1986.

Year	Frequency
1981	1 per 5.1 patient months
1983	1 per 6.7 patient months
1985	1 per 6.7 patient months
1986	1 per 6.7 patient months

tors associated with high rates of peritonitis.

Rubin et al have stressed the point that registry data may not reflect local experience, and that criteria for patient selection "must be relevant to the patient population treated in a particular center."[5] We agree, and would encourage other centers to develop and review their own morbidity data.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

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2.5 mg/24 hr	12.5 mg	5 cm^2	30 Systems (NDC 0083-2025-26) *100 Systems (NDC 0083-2025-30)
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10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

*Hospital Pack 100's

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All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA.

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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. 5685

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2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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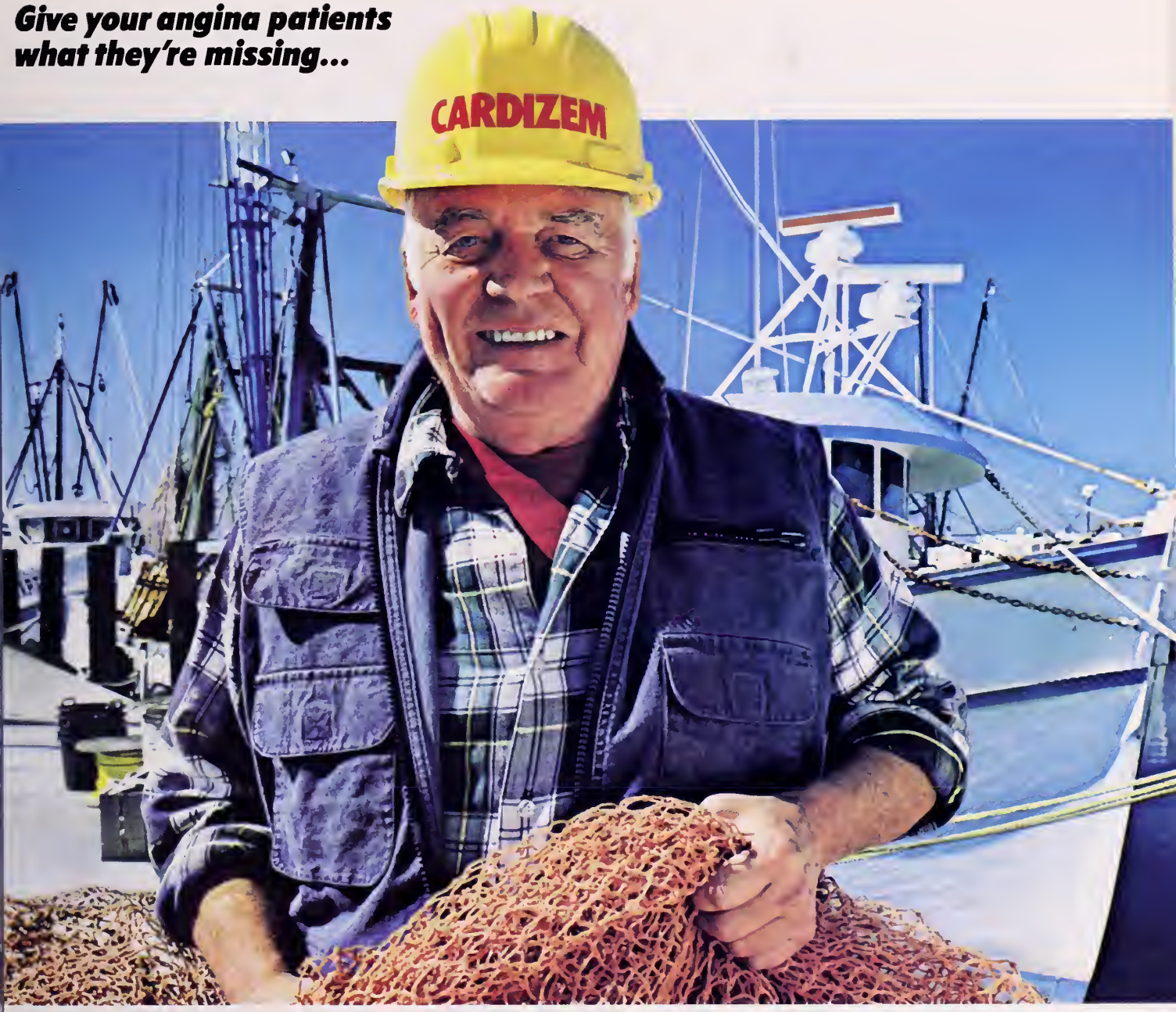
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Please see brief summary of prescribing information on the next page.



CARDIZEM® FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

diltiazem HCl/Marion

60 mg tid or qid

Brief Summary
Professional Use Information

CARDIZEM®
(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%).

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

See complete Professional Use Information before prescribing.

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SPECIAL ARTICLES

Experience from a New Wave Ambulatory Surgery Center

Michael Hedden, F.F.A.R.C.S., and K. Donald Wolfe, C.R.N.A.

ABSTRACT: A description is presented of the first two-years experience from a hospital affiliated ambulatory surgery center. This center differs in that its surgical base includes practically no gynecological or pediatric patients, resulting in a population of which 63% are over 60 years of age and 32% are ASA Physical Status (PS) 3 or worse. Hospital admissions following surgery were 0.66%. Only the heart and urinary tract related problems could be considered a direct result of our different patient population.*

**PS = American Society of Anesthesiologists' Physical Status Classification.[1]*

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K. DONALD WOLFE, C.R.N.A.
Dr. Hedden, a Fellow of the Faculty of Anaesthesia of the Royal College of Surgeons, is in the private practice of anesthesiology and Mr. Wolfe is Staff Certified Registered Nurse Anesthetist at the Southwest Florida Regional Medical Center in Ft. Myers.

The Ambulatory Surgery Center (A.S.C.) of Southwest Florida Regional Medical Center (S.F.R.M.C.) opened in March 1984 in a building directly across the street from the main hospital which was renovated for hospital expansion with 14,000 sq. ft. being converted into the surgery center.

The location of the unit gives us the advantages of both in-hospital and free-standing units without inheriting their disadvantages. We enjoy the back up features provided by the parent hospital, but we are functionally independent enough to completely develop our own environment and methods. It may be difficult to achieve an efficient system for outpatient surgery or develop the differences in approach necessary unless the unit is sufficiently independent to be free of the in-hospital environment.[2,3]

Preoperative visits • When establishing the guidelines for practice for the unit we mandated a preoperative visit for all patients needing anesthesia services. During this visit, the patients are registered and seen by the anesthesiologist and preoperative nursing staff. The anesthesiologist completes a history and designates necessary laboratory tests (unless previously ordered by the surgeon). We insist on a current Hb and urinalysis for all patients, an EKG in patients over 40 years of age, and a serum K for those on blood pressure medications. We accept laboratory work from other reliable sources and occasionally order additional tests and/or x-rays. The nurses staffing the preoperative area instruct the patients on time of arrival, suitable clothing, approximate length of stay, arrangements for transportation and first night supervision. They stress NPO after midnight the night before surgery and go over in detail the experiences to be anticipated during the operative and perioperative period. Phlebotomies, cardiograms, and

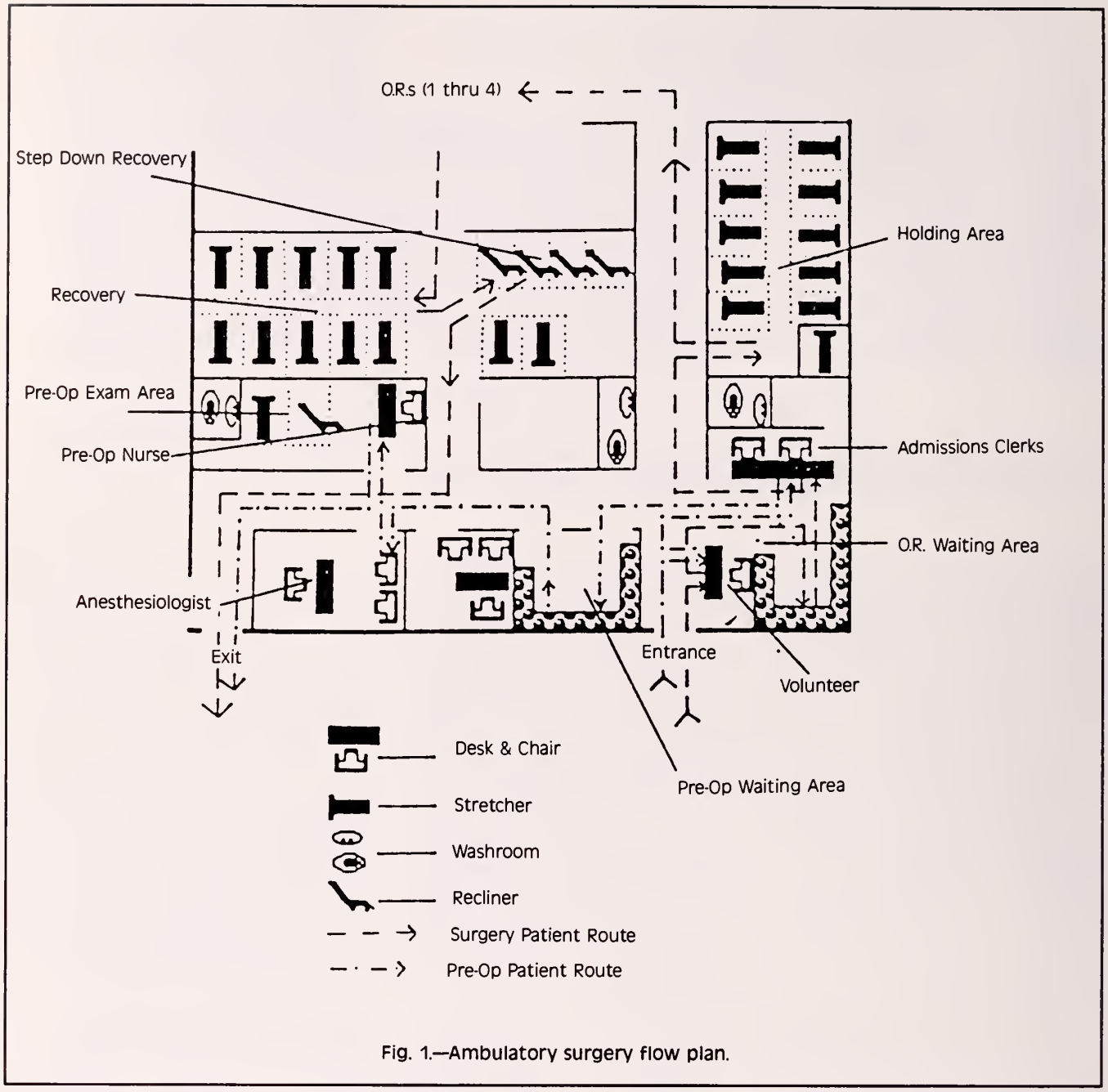


Fig. 1.—Ambulatory surgery flow plan.

physical examinations are done at this time as necessary. Specimens are analyzed in the main hospital and reported on by the appropriate specialists. The results are collated with the patient charts at least 24 hours prior to surgery and abnormalities reported to the medical director for any action necessary.

Preoperative visits for outpatient surgeries are especially important and we believe they should not be supplanted by alternate forms of assessment.[4-6] Our ability to reduce perioperative medications in the outpatient setting is to a large extent governed by the patients' better expectation of health, fostered by an environment they are comfortable with, i.e., the A.S.C. in the perioperative period and home thereafter. The preoperative visit is vital for this comfort. In addition it allows for all the other ingredients of rational and thoughtful anesthesia/medical preoperative decisions.

Ambulatory surgery facility • In our unit, 1,600 sq. ft. are operating rooms. The flow paths and space were specifically arranged to allow separation of patients coming for preoperative visits and surgery (Fig. 1). In addition larger spaces were assigned holding and recovery areas in the A.S.C., compared with the main hospital. This emphasis has worked well for us. To some extent the space distribution works because of pre- and postoperative philosophies that differ with that found in some units.[7] All patients are put on rolling beds in the holding unit. This not only facilitates IV placements and the adminsitration of

	SFRMC ASC '84/85	%	Freestanding CI's '79	%
1	Cystoscopies	32	D&C	15
2	Cataracts	26	Tubal Ligations	11
3	Arthroscopies	10	Myringoscopies	10
4	Other Orthopedics	7	Orthopedics	8
5	Breast Biopsies	4	Exc. of Skin Lesions	6
6	Corneal Transplants	3	Dental	4
7	Other Ophthalmics	3	T's & A's	4
8	Herniorrhaphies	2	Vasectomies	3
9	Vitrectomies	2	Laparoscopies	3
10	Laparoscopies	2	Cystoscopies	3

Fig. 2.—Most frequently performed surgeries.

short-acting hypnotics for regional blocks but allows for privacy and relaxation. Thirty two percent of our patients (patients having opthalmic operations) are put to sleep in the holding area so that they will have no recall of their nerve blocks.

Similarly our recovery room is mainly a bedded area. Patients are encouraged to sit up, take juice, coffee, crackers, or soup, and have family visits as soon as practical. However, once they are ready to ambulate to the reclining chairs, they are for all intents and purpose ready for discharge. Thus, although we have a two-stage recovery system, they are both located in the same area and staffed by the same nurses.

Patient population • It was not clear initally whether our outpatient facility would prosper, considering the main hospital had no pediatric or obstetric divisions. These specialities have traditionally provided most outpatient referrals. Several factors seem to have contributed to the popularity of our unit and in less than a year we were performing more than 400 procedures a month. These factors included: (1) Medicare's dictum requiring preadmission certification for inpatient surgery on most ocular procedures, hernias (femoral and inguinal), D&Cs, breast biopsies and anal procedures.[8] (2) Surgeons finding it increasingly difficult to get reimbursed for facility expenses when doing in-office surgery. (3) The rapid advancement in endoscopic instrumentation and subsequent popularity of such examinations and operations.

Figure 2 shows our ten most frequently performed operations compared with the top ten amongst all free-standing units in 1979 as reported by Bruns.[9] The dissimilarity of these lists is impressive. Our different patient base and operative type naturally also affect the age distribution (Fig. 3) and the physical status of the patients we see. Sixty three percent of our patients are over 60 years of age and 32% are ASA Physical Status 3 or worse. Obviously, we had to broaden the usual criteria for patient selection for day-surgery. In fact, we find it more useful to select our patients by criteria other than physical status and the facility guidelines state: "Patients who are not expected to require, a) A prolonged recovery room phase,

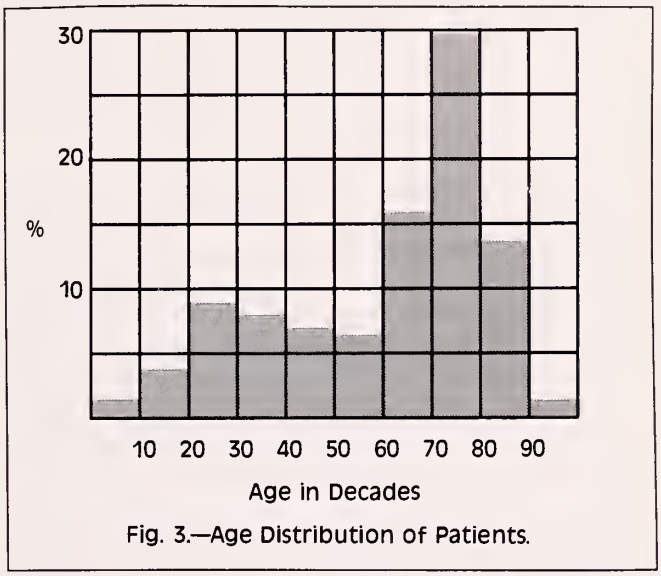


Fig. 3.—Age Distribution of Patients.

b) Prolonged and/or invasive monitoring, c) Invasive physiological support, d) Post-surgical hospital admission, and who can ensure 1) Appropriate post-A.S.C. chauffered transportation, 2) Suitable home supervision and care, are acceptable for ambulatory surgery."

We occasionally accept patients who have a fair chance of needing post-surgery admission when the advantages of not exposing the patient to the hospital environment outweigh this risk. Indeed we have an addendum to our anesthesia consent form which says "If your surgery/medical condition changes during your stay at A.S.C., such that you need continuing care, you will be transferred to S.F.R.M.C. Under these circumstances you will incur additional expenses." In spite of this attitude, our hospital admission rate has not been particularly high (0.66%) compared to others.[10, 11] This fact we attribute, in part, to the recognition that outpatient anesthesia is not just a shortened version of inpatient anesthesia but requires a different philosophy of approach and some different anesthesia methodologies.

Anesthesia methods • We have adopted several variations on the anesthetic techniques used in our inpatient practice. No preoperative medications are given

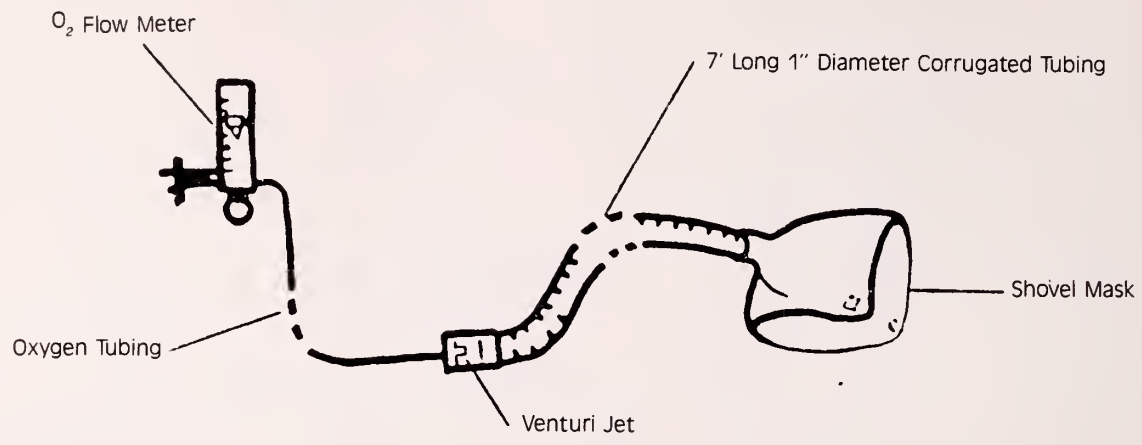


Fig. 4.—Oxygen delivery system for eye surgery.

unless we have an extremely anxious patient or have elicited a history of debilitation nausea and vomiting following anesthesia. Under these circumstances we usually give a small dose of Valium and/or Fentanyl IV for anxiety and 0.1—0.2 ml Droperidol or apply a Transderm V patch for nausea.[12, 13]

We use Brevital inductions for general cases requiring ETTs and concurrently give an intubating dose of Tracium or Norcuron.[14, 15] Mask ventilation with N_2O/O_2 50/50 and Forane or Ethrane in 1-2 Mac concentrations are used until intubating conditions are achieved, as evidenced by a block aid monitor. Depolarizing muscle relaxants are reserved for small children or anticipated difficult intubations. Fentanyl 0.5 ml aliquots is used, in addition to the previously mentioned drugs, for pain control during anesthesia and in the early (before oral medications can be tolerated) postoperative period. We limit the total dose to between 2 and 3 ml.

Thirty one percent of our operations are ophthalmic, mostly cataracts. Our routine is to perform the nerve blocks (we use a combination of postauricular facial and retrobulbar blocks except for one surgeon who prefers the Van-Lent approach to the facial nerve) in the holding area under Brevital anesthesia. Base line vital signs are obtained, 0_2 administered, EKG displayed, a sleep dose of Brevital given, and the nerve blocks performed. A Honan balloon is applied and the block checked and/or pressure relieved at ten minute intervals. The operation is then conducted on an anesthesia stand-by basis. We prevent a claustraphobic atmosphere under the eye drapes by providing a continuous high flow of oxygen enriched air via a venturi entrainment system to a shovel mask (Fig. 4). In order to keep the venturi beyond the drapes, seven feet of corrugated tubing is inserted between the jet and the mask. This changes the dynamics of the venturi, but by running 4L of O^2 through a jet theoretically delivering a $F10^2$ of 0.24 (Diverse Pulmonary, Inc.), we get a delivered 0^2% of approximately 29 and a flow rate of 30 L/minute. We double room most of our opthalmic surgeons and with this approach to analgesia we manage a zero turn-over time.

For urology endoscopic anesthetics and other short procedures not needing E.T.T.s, 20 g Heparin locks are inserted in the holding area. These are flushed on entering the O.R. through an 18 g needle with N saline from a regular IV connected to a 3-way extension. The 3-way extensions and needles are discarded between cases. Anesthesia is obtained with small doses of Brevital (20—60 mg aliquots) given immediately before very stimulating points in the procedure over a background of sedation provided by Fentanyl (0.5 ml aliquots to a maximum of 2.0 ml) and Valium (1.25 mg aliquots to a maximum of 5.0 mg). We have tried Sylvan Shane's Vistaril/Nisentil conscious sedation method in the past but substituted the one described after a few patients developed painful superficial thrombophlebitis of the drug recipient vein.[16] We sometimes substitute Nisentil (5 mg aliquots to a maximum of 20 mg) for the Fentanyl in operations lasting more than 15 minutes and are now replacing Valium with Versed in the hope of reducing phlebitis to a minimum.[17]

Arm and hand procedures are invariably performed under regional anethesia, either axillary brachial blocks or in shorter cases the Bier-Holmes intravenous technique. We have not, however, used regional techniques for leg or lower abdominal procedures as others have described.[18]

Hospital admissions and follow-up • A breakdown of hospital admissions by etiology is shown in Figure 5. Only the "heart related" admissions and those due

			%1		%2
1	Heart related rhythm disturb		16		.10
			24		.15
	Ischemia		8		.05
2	Somnolence			20	.13
3	Nausea & vomiting			16	.10
4	Lacking home supervision			12	.08
5	Further sugery			8	.05
6	Post op. bleeding			4	.03
7	Xylocaine toxicity			4	.03
8	Pneumothorax			4	.03
9	Pain			4	.03
10	Urinary retention			4	.03
	Total	=		100	.66

(%1 = % hospital admissions; %2 = % of all ASC patients receiving anesthesia.)

Fig. 5.—Etiologies of hospital admissions.

			%1		%2	
1	Pain	Op. site	.55		16	
		I.V. site	.60	1.40	17	40
		Muscle	.25		7	
2	Nausea & vomiting			1.30	37	
3	Urinary retention			.30	8	
4	Sore throat			.25	7	
5	Bleeding			.15	4	
6	Drowsiness			.05	1	
7	Bell's palsy			.05	1	
	Total			3.50	100	

(%1 = % of all ASC patients receiving anesthesia; %2 = % of total follow-up complaints.)

Fig. 6.—Patient complaints at follow-up.

to urinary retention stand out as a product of our particular patient population.

The "heart related" patients were all A.S.A. Physical Status 3. All had significant cardiac histories and all were older than 75 with a mean age of 83. Two of the six patients were admitted prior to surgery, one following an episode of V.T. and the other after developing a supraventricular tachycardia resistant to short-term therapy. Of the other four, two developed ischemic patterns in the perioperative period, one going on to a myocardial infarction; one developed congestive failure, and one second degree heart block with a pronounced bradycardia. All went on to full recovery. Probably none of these patients would have had a difference in therapy or outcome had they had inpatient surgery. However, from this small sample the need for admission rises in this group of patients, i.e., those older than 75 with a significant cardiac history.

Urinary retention was a reason for admission in one patient only but a complaint at follow-up in six (Fig. 6). Some of these were seen the evening of surgery in the E.R. for strait catheterization and others just complained of difficulty in urination. Patients complaints are documentd by the recovery room nurses. They attempt to follow-up all patients with telephone interviews guided by a printed interview format. Generally, the A.S.C. experience is overwhelmingly positive as evidenced by the telephone interviews.

Conclusions • Our anesthesia group comprises six anesthesiologists and 14 C.R.N.A.s. The anesthesiologist director of the unit and the chief C.R.N.A. spend somewhat more than half of their working time in the unit while the rest of the staff rotates through on a regular basis. This allows everyone to maintain their skills in all facets of our anesthesia practice but also gives the unit stability of direction. It is sometimes difficult to convince anesthesia personnel that techniques used for inpatient practice may not be the best for outpatients and that one is not just a shortened version of the other. Other adaptations that we have developed—informal atmosphere, increased involvement of patients' friends and relatives, allowing undergarments, false teeth, and nail varnish to remain on—can strike against motherhood and apple pie but probably have important implications in the process of creating an atmosphere of health. This is not to say that these changes cannot be taken too far and a party atmosphere is not our goal. Some of our "innovative" ideas have been relabeled by colleagues and subsequently abandoned. On the other hand many of the best ideas have come from personnel whose principal responsibilities are not ambulatory surgery. Thus, the staff rotation has been mutually advantageous.

From our experience it is apparent that an outpatient surgery facility can cope with an older and sicker patient population than is usually envisaged. We seem to be managing without experiencing a prohibitive hospital admission rate and would like to think this is in part due to a structured presurgery system combined with techniques particularly adapted for this type of population. There is no doubt as to the popularity of the unit. We have already outgrown our original four operating rooms and have recently opened two more.

Acknowledgment

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The teacher becomes a patient: teaching interviewing to medical students

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ABSTRACT: A novel program is described for the teaching of psychiatric interviewing to medical students. This program involves simulations of psychiatric patients by a faculty preceptor as well as interviewing of actual patients. Advantages are discussed.

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The physician's ability to listen and communicate with the patient is crucial to their relationship, affecting both patient satisfaction[1] and compliance.[2] Over the past decade, the teaching of interviewing skills has received increasing focus in medical education.[3] Though less than half of American medical schools offer such training in the clinical years, continued instruction and practice at that time can lead to increased efficiency.[4] Historically, psychiatry departments have been instrumental in teaching interviewing skills, although primarily in the preclinical years.[5] After learning basic interviewing skills during the preclinical years, however, students have identified the need for additional experience in coping with patients' emotions, structuring the interview, and developing diagnostic hypotheses.[6] These needs can be addressed ideally in a psychiatric clerkship. It is in this context and to this need that our preceptorship program was developed.

The overriding criterion was to develop a format that provided what Spiegel called a "motivational environment," i.e., an environment in which students are able to develop critical thinking skills in an atmosphere of approval and support with room for trial and error.[7] To carry this out, live observation with an opportunity for immediate feedback was chosen, as this process has been reported to lead to skill improvement.[8]

To provide this immediate feedback, simulated as well as actual patients were used. Though feedback can be provided after the completion of an actual patient interview, the use of simulations allows the interview to be stopped for immediate feedback without harm to patients.[5]

In other reported programs, simulated patients have been fellow classmates,[5] professional actors,[9] or trained volunteers.[10] The limitations are students'

preference for simulated patients who were not classmates[6] and the cost of training and reimbursement of actors and volunteers. To overcome these limitations, one of the faculty preceptors served as the simulated patient. This allowed psychiatric syndromes to be presented closely following diagnostic criteria, so that students could more easily learn the classification scheme before seeing actual patients who typically presented mixed diagnostic pictures.

Program description • The Psychiatry Clerkship at the University of Florida involves primarily an eight-week rotation on various inpatient units. In addition, most of the approximately 20 students are involved in interviewing preceptorships with faculty members for about two hours per week. The clerkship year follows a six-week lecture series in clinical psychiatry and a 13-week interviewing seminar in which each student performs one supervised interview of a psychiatric patient in a small-group setting.

Our program involved three clerkship students for two hours per week during six weeks of the rotation. The focus was to promote differential-diagnostic thinking and to teach the student clinical interviewing skills needed toward that end. A great deal of discussion emphasized which information was needed from a patient to rule in or out a given diagnosis, as well as very specific work on how to ask for various historical items.

The first session was didactic, reviewing the structure of the psychiatric interview and Mental Status Examination. The broad range of historical items to be potentially explored was outlined, with examples of how these could be investigated with different types of patients.

During the next two sessions, each student interviewed two simulated patients. The simulations were performed by one faculty member (L.K.G.) while the other (J.T.S.) offered prompting and feedback during the interview. Especially useful was the ability of either preceptor to interrupt the interview at any point to discuss the student's effectiveness or any difficulties encountered. Subsequently, the student would usually be asked to "back up" so that he could modify his technique while being provided with the same material from the "patient." Also during these simulated interviews, the student would be stopped after two to three minutes to discuss his initial differential-diagnostic impression. A discussion of the student's strategy for the remainder of the interview followed, including diagnostically important areas to be covered and appropriate techniques for the given "patient." In the course of these simulation, the other students were quite active in giving feedback to the student interviewer.

Following this preparation, the last three sessions involved 30-minute interviews with actual psychiatric inpatients, two by each student. After the interviews, the students were asked to briefly present their patient and to discuss the differential diagnosis. Their discussion was directed toward specific historical items and their differential-diagnostic significance. During this discussion, students would often become aware of important omissions in the history. When this occurred, they would discuss how they might have explored that item, or frequently they would actually explore the missing material via a brief simulation.

Discussion • The improvement of interviewing skills is essential in fostering better physician-patient relationships.[1] The previously discussed program provided students such an opportunity in the clinical years. Similar to other reported preceptorships, there was a focus on the process of the interview via feedback to the student. Further, as reported in other formats using simulated patients,[8-10] our feedback was immediate and the student could re-practice difficult or ineffective interactions without adversely affecting the "patient."

Unique to this program was the use of a faculty member as a simulated patient. This had several distinct advantages. The simulation of psychopathology is difficult, possibly not within the realm of ability of classmates, volunteers, or even professional actors (at least without extensive and costly training). A faculty member is readily available without additional cost and has the experience and training necessary to present fairly classical psychiatric syndromes. This enables the previously inexperienced students to more readily recognize syndromes in actual patients. In addition, the teacher/-"patient" was more qualified to give clinically constructive feedback to students than an actor or volunteer; he could identify verbal and nonverbal cues that the student failed to explore, clarify his emotional responses to the student's questioning, and suggest alternative approaches from the "patient's" point of view.

The development of differential-diagnostic strategies was effectively taught by stopping the interview intermittently. Feedback at those points urged students to generate differential-diagnostic strategies and proceed in a methodical fashion with the remainder of the interview. These critical skills are felt to be essential in practice beyond medical school.

In conclusion, this program, using a faculty preceptor as a simulated patient, provided students with a valuable learning environment. This environment offered a classical presentation of psychiatric syndromes, the opportunity for repeated practice of difficult interactions, immediate rather than delayed feedback from the "patient" and others, and structuring of the interview to encourage both differential-diagnostic clarification and technical skill. It is believed that further development of such preceptorship programs should be encouraged.

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Career options and practice patterns of surgical specialists following residency training: national trends in fellowship training and subspecialty education

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ABSTRACT: For the immediate future, there will be little change in the number of surgeons entering practice in the medical community. There continues to be an outward diffusion of surgical manpower with the saturation of medical-surgical practice in urban communities. Previous studies suggest a substantial growth from 1971-1978 in surgical manpower amounting to a 45% increase in certified surgeons and 17% increase in residents over this eight-year interval. The net effect was a total growth of 16% in surgical manpower. With the increase in the number of practicing physicians in the United States holding certification in at least one specialty, projections predict that by 1990 there will be too many physicians as a consequence of continuing geographic and specialty maldistribution.

Studies by the American College of Surgeons provide evidence that the estimates of surgical residents in accredited programs used as a surgical manpower basis of the Graduate Medical Education Advisory Committee (GMENAC) and the Department of Health and Human Services (DHHS) are not as great as initially projected. Thus, previous data may be inflated extrapolations of the new, fully-trained surgeons available for the State of Florida and the United States. No substantive change in the number of active surgeons entering practice is expected.

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The 20th century can be truly considered the "age of the surgeon." The development of anesthesia, blood-banking, antibiotics, and the application of modern surgical principles via training have extended therapeutic potentials to a degree previously considered impossible. Major surgical illnesses that previously were considered uniformly fatal, (e.g., major trauma, cardiac disease and cancer, etc.), now uniformly respond to a surgical therapy. Additionally, the risk inherent with the performance of standard surgical procedures such as appendectomy, cholecystectomy, and hernia repair has dropped to negligible levels secondary to the application of sound physiologic principles and pre- and postoperative care.

In 1982, of 501,958 practicing physicians in the United States, 34.6% were primary care physicians and 23.7% of the practice population were surgeons (including obstetrics and gynecology).[1] For the immediate future, there will be little change in the number of surgeons entering the medical community. Surgeons who will begin to practice within the next five years are currently enrolled in training programs. There continues to be an outward diffusion of surgical manpower as the saturation phenomenon becomes manifest in urban communities. The surgical manpower distribution was best documented by Moore and Lang,[2] who reviewed this distribution from 1971 through 1978, with extrapolations to 1980, and revealed that there has been a substantial growth in both absolute numbers of individuals practicing surgery and in the board-certified group. This study suggests a substantial growth, amounting to 44.6% in certified surgeons and 17.3% in residents during this eight-year interval. The net effect was a total growth in surgical manpower of 16% during this period.

Surgery and its broad subspecialty disciplines continue to follow the national trend toward increased

board certification, and the number of uncertified individuals practicing surgery fell by nearly 50% during this interval. Thus, by 1990, projections state that nearly all practicing physicians in the United States will hold certification in at least one specialty. The Graduate Medical Education National Advisory Committee (GMENAC) was the federally funded committee that made elaborate projections of physician numbers and national health care demands. This committee predicted three years ago a 70,000 physician surplus by 1990 and a 145,000 surplus by the year 2000. The debate continues as to whether these numbers reflect "too many physicians" especially with the continuing geographic and specialty maldistribution. Nonetheless, surplus physicians with overtraining in specific surgical specialties were exemplified in general surgery (150%), urology (120%), orthopaedic surgery (135%), obstetrics/gynecology (145%), plastic surgery (145%), and neurosurgery (190%). As a result of this maldistribution and excess population of surgeons, the Residency Review Committees of the various specialties in surgery have dropped a significant number of physicians from their graduate educational programs.

Growth of surgical manpower • Table 1 depicts the differential growth for the various surgical specialties during the period 1971-1978. Total growth of surgical personnel was nearly 30% during this time interval, but there was considerable variation for each specialty in its growth pattern.[3] For example, general surgery had a modest 9% growth while urology, orthopaedic surgery, and plastic surgery had exceptionally high growth rates of 46%, 45%, and 71% respectively. Thoracic surgery continued to control its manpower situation in an extraordinarily effective fashion to 22%; whereas, growth in other specialties ranged from 30% to 40%. Table 2 denotes the distribution for the number of board-certified surgeons in active practice together with their population ratio. Obstetrics/gynecology and general surgery have fairly high population ratios as is expected from the nature of the clinical practice that these groups perform. The purpose of these two specialties is to serve the general problems of relatively large portions of the population. In contradistinction, colon/rectal, plastics and neurological surgery have quite low population ratios with their confined narrow specialty demands. The other group of specialties (ophthalmology, orthopaedics, otolaryngology and urology) serve an intermediate role to meet semi-specialized needs of relatively large segments of the population. These population ratios well reflect their pattern of practice.

Geographic distribution of surgical manpower • A major contribution to the geographical distribution of medical manpower was published in 1980 by Schwartz et al.[4] This report examines the distribution of board-certified specialists among cities and towns of varying sizes and at three points in time: 1960, 1970, and 1977. The various specialties examined include general surgery, urology, and neurosurgery. There was a remarkably uniform distribution of specialty practice in cities over 30,000 population throughout the 23 states sampled. However, in 1970 and 1977 there was a distinct alteration in the pattern of distribution with the result that in 1977, 71% of all communities with a population of 10,000 had surgeons in practice. Thirty eight percent of communities in the 5,000—10,000 range had surgeons as did 14% of the towns with populations greater than 2,500. Similar but less dramatic shifts of the same order were seen for urology and neurosurgery.

It is apparent that larger numbers of specialists

Table 1.—Differential Specialty Growth, 1971-1978.

Neurosurgery	31.0%
Ob/Gyn	33.7
Ophthalmology	39.1
Orthopaedics	45.1
Otolaryngology	30.3
Plastic Surgery	71.4
Surgery	9.0
Thoracic Surgery	21.8
Urology	45.8
Colon/Rectal	27.3
TOTAL	29.5%

Adapted from Zuidema, G.D.: Bulletin: The American College of Surgeons 69(4):2-8, 1984.

Table 2.—Board-Certified Surgeons in Practice, 1977-78.*

	Number	Pop. Ratio
Neurosurgery	1,837	0.84
Ob/Gyn	13,754	6.31
Ophthalmology	7,824	3.59
Orthopaedics	8,685	3.99
Otolaryngology	4,327	1.98
Plastic Surgery	1,557	0.72
Surgery	15,294	7.02
Thoracic Surgery	2,915	1.34
Urology	4,592	2.10
Colon/Rectal	298	0.14
TOTAL	61,083	28.1

*Excludes residents, noncertified surgeons, administrative, federal and research physicians. Corrected for double certificate boarding.

Source: Moore, F.D. and Lang, S.M.: N. England J. Med. 304:1078-1084, 1981.

are opening offices in smaller communities as they complete their training. This observation is also supported by Schwartz et al,[4] who studied the metropolitan and nonmetropolitan distribution of specialists in 1960 and 1977 on a population-ratio basis (Table 3). These authors confirmed that nonmetropolitan distribution of specialists has more than doubled in virtually every incidence during this time period.

Table 3.—Board-Certified Specialists in Surgery per 100,000 Persons in Metropolitan and Nonmetropolitan Areas, 1960 and 1977.

	1960		1970	
Specialty	Non-metro	Metro	Non-metro	Metro
Surgery	2.3	6.6	5.0	10.0
Neurosurgery	0.06	0.74	0.15	1.5
Urology	0.39	1.9	1.1	3.2
Ob/Gyn	0.56	3.8	2.4	7.7
Medicine	1.6	8.3	5.0	20.0

Source: Schwartz, W.B., et al: N. England J. Med. 303:1032-1038, 1980.

The forces that interact to allow a physician to choose a geographic location for clinical practice depend upon multiple factors and include: (1) the practice opportunities provided the individual upon completion of his/her residency and (2) the laws that govern the differential levels of remuneration. Practice opportunities can be further divided into academic versus private practice incentives. Clearly, that individual who has geared himself to a university-based program and who has invested heavily into basic-applied or clinical research is in a much more advantageous situation to enter the academic surgical environment. This opportunity, afforded to approximately 5% of finishing chief residents, represents a major career decision with the frequent necessity of expenditure of greater professional time and less remuneration than offered in the private practice setting. Individuals trained predominantly in community-based surgical and subspecialty programs arc more likely to enter the private sector where fringe benefits and total remuneration usually exceed those of academic programs.

There is the implication that a disproportionately large fraction of physicians prefer to live and practice in urban areas and, thus, are expected to earn less money than their colleagues in nonmetropolitan regions. The data provided by Schwartz et al[4] supports this prediction and suggests that physicians practicing in metropolitan areas with populations that exceed one million earn 13% less in real terms than did their colleagues based in nonurban areas, and that they worked 7-9% fewer hours.

Future projections of physician-surgeon availability ● From the aformentioned studies, the GMENAC report,[5] the 1984 Report to the President and Congress by the Department of Health and Human Services (DHHS),[6] and the 1985 Projections of Physicians Supply in the United States by the DHHS[7] suggest that surgical specialists are in oversupply and this condition will, in the absence of controls, increase into the next century. From data collected in 1982, program directors in surgical specialities observed that there has been little change in the total number of surgical residents trained over the past three years. The number of residents was 14,792 in 1984-85; this represents a decrease of 0.7% from the 1983-84 enrollment (Table 4). Of 14,792 residents, 57.2% were in general surgery programs; a decline of about 2% from enrollment totals two years previously. The next largest specialty was orthopaedics, with 2,719 residents; down from 1983-84 by 1.3%. Of the remaining eight surgical subspecialties, only two recorded increases from the 1983-84 total—neurosurgery (up 0.9%) and otorhinolaryngology (up 2.2%). Recent data from the American College of Surgeons (ACS) suggest a future reduction in the number of surgical residents can be anticipated on the basis of three successive years of decreasing enrollment within the first curricular year of surgical residency. Unless a dramatic increase in the number of incoming residents in 1985-86 is apparent, surgical residency enrollment will decline in the future. General surgery will exhibit the largest decline in first curricular year enrollment and decrease approximately 7% between 1982-83 — 1984-85. As general surgery training is a prerequisite for enrollment in many surgical specialty programs, a decline in the number of enrollees during the next few years will probably presage declines in the nine other surgical specialties. In addition, colon and rectal surgery showed a significant reduction in first curricular year enrollment between 1982-83—1983-84 — a decrease of 6%. Four surgical specialties, in addition to general surgery, showed a reduction in first curricular year enrollments: pediatric surgery 23.5%, thoracic surgery 12.3%, plastic surgery 5.7%, and neurosurgery 3.5%.

The study by Misek and Hynds-Karnell[8] of the ACS uncovered substantial evidence that estimates of surgical residents in accredited programs used as a surgical manpower basis of the GMENAC[5] and DHSS[6, 7] studies are not as great as initially projected. Thus, these data probably lead to inflated extrapolations of new, fully-trained surgeons. If the overall projections for surgeons in 1990 reported by the GMENAC and DHSS studies are realized, it is probably that the difference between the ACS totals and these totals would be due to a large number of physicians entering the profession who have not completed board-certification requirements in accredited programs.

Table 4.—American College of Surgeons Numbers and GMENAC Projections of Surgical Residents, 1982-1990.

Specialty	ACS Counts 1982-83	1983-84	1984-85	Actual Growth Rate 1982-83 to 1984-85	Required Growth Rate to Equal GMENAC Projections	GMENAC 1990 Projections*
General Surgery	8,654	8,517	8,454	(2.3%)	7.8	9,200†
Orthopaedic Surgery	2,583	2,754	2,719	5.3	15.8	3,150
Otorhinolaryngology	1,025	1,050	1,073	4.7	30.8	1,400
Urology	979	985	968	(1.1)	65.3	1,600
Neurosurgery	628	755	762	21.3	(8.1)	700
Plastic Surgery	424	448	429	2.1	39.9	600
Thoracic Surgery	292	304	297	1.0	51.5	450
Colon/Rectal Surgery	50	47	47	(6.0)	†	†
Pediatric Surgery	30	30	30	0	†	†
Vascular Surgery	††	††	13	††	†	†
TOTAL	14,667	14,890	14,792	0.8%	15.6%	17,100

* Source: The GMENAC Summary Report, Vol. 1, DHHS, (Sept. 1980).
† Colon/rectal surgery, pediatric surgery, and vascular surgery resident counts are included in those of general surgery.
†† Vascular surgery programs not initiated until 1984-85.

NOTE: Obstetrics/gynecology and ophthalmology residency programs were not included in ACS counts.
Source: Misek, G. and Hynds-Karnell, L.: Bulletin: The American College of Surgeons 71:4-9, 1986.

The choice of fellowship training and subspecialty education after general surgery • All specialties of surgery depend upon general surgery for education, clinical service and research. The discipline of general surgery remains the unifying force of surgical practice upon which all subspecialties of surgery depend. Over the past three decades, this specialty has become increasingly important for resident education in neurological surgery, otorhinolaryngology, orthopaedics, and urology.

The most prevailing decision to enter a subspecialty of surgery is the resident's interest in the disease processess and the operative techniques that must be acquired within the specialty discipline. Thus, the individual's decision to enter urology or otolaryngology is usually formulated on the great interest of genitourinary disorders/tumors or similar diseases of the ear, nose and throat, respectively. Further, the decision to embark upon advanced specialty training as a fellow in surgical oncology, vascular surgery, cardiothoracic, renal transplantation, etc., stems from similar desires to expand one's expertise of clinical and basic sciences related to these respective disciplines.

The discipline of general surgery has responded effectively to the changes of surgical specialization. In the field of education, general surgery assumes a leadership role for developing comprehensive systems of education in core (basic) surgery that is sound in concept and effective in practice. The resident who is nearing completion of training or in the early phases of planning a professional career should realize the remarkable advantages of the comprehensively trained physician in the principles and practices of general surgery and the broad interrelationship it commands with all the surgical specialties. The decision to continue training in a subspecialty or a fellowship beyond general surgery must be tempered by that individual's motivation to strengthen their surgical practice, education and research opportunities.

Conclusions • At present, there will be no substantive change in the number of active surgeons entering medical practice in communities throughout the nation This trend would also be expected for the State of Florida, as surgeons who will begin to practice within the next three to five years are currently enrolled in specialty training programs. While total growth of surgical personnel approached 30% in the 1970s, there was considerable variation for each specialty in its growth pattern. During this interval, extraordinarily effective control of growth was evident in cardiovascular-thoracic surgery, while a modest growth of 9% was evident in general surgery. Exceptionally high growth rates were noted in urology (46%), orthopaedic surgery (45%) and plastic surgery (71.7%). Expectantly, specialists such as obstetrics/gynecology and general surgery with high population ratios will continue to serve the general problems of relatively large portions of the population. Low population ratios such as colon/rectal, plastic and neurological surgery will, by necessity, control their

specialty growth as is reflected by the confined specialty demands of these professions.

The studies by Misek and Hynds-Karnell[8] of the American College of Surgeons are at variance with the surgical manpower studies of GEMNAC and DHSS. With inflated extrapolations of new, fully-trained surgeons provided by GEMNAC and DHSS, these differences in the two studies are best explained by an increasing number of physicians who will enter the profession but are not yet board certified. Thus, for the 1990s the State of Florida may not experience the oversupply of surgical specialists provided by the GEMNAC studies if manpower projections are realized from program directors in surgical specialties and that of the American College of Surgeons.

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Before prescribing, please consult complete product information, a summary of which follows:

MICROBIOLOGY The bactericidal activity of ceftriaxone results from inhibition of cell wall synthesis. Ceftriaxone has a high degree of stability in the presence of beta-lactamases, both penicillinases and cephalosporinases, of gram-negative and gram-positive bacteria. Ceftriaxone is usually active against the following microorganisms *in vitro* and in clinical infections (see Indications and Usage):

GRAM-NEGATIVE AEROBES: Enterobacter aerogenes, Enterobacter cloacae, Escherichia coli, Haemophilus influenzae (including ampicillin-resistant strains), *H parainfluenzae, Klebsiella* species (including *K pneumoniae*), *Neisseria gonorrhoeae* (including penicillinase and nonpenicillinase producing strains), *Neisseria meningitidis, Proteus mirabilis, Proteus vulgaris, Morganella morganii* and *Serratia marcescens*.

Note: Many strains of the above organisms that are multiply resistant to other antibiotics, e.g., penicillins, cephalosporins and aminoglycosides, are susceptible to ceftriaxone sodium.

Ceftriaxone is also active against many strains of *Pseudomonas aeruginosa*.

GRAM-POSITIVE AEROBES: Staphylococcus aureus (including penicillinase-producing strains) and *Staphylococcus epidermidis* (Note: methicillin-resistant staphylococci are resistant to cephalosporins, including ceftriaxone), *Streptococcus pyogenes* (Group A beta-hemolytic streptococci), *Streptococcus agalactiae* (Group B streptococci) and *Streptococcus pneumoniae* (Note: Most strains of enterococci, *Streptococcus faecalis* and Group D streptococci are resistant.)

Ceftriaxone also demonstrates *in vitro* activity against the following microorganisms, although the clinical significance is unknown:

GRAM-NEGATIVE AEROBES: Citrobacter freundii, Citrobacter diversus, Providencia species (including *Providencia rettgeri*), *Salmonella* species (including *S typhi*), *Shigella* species and *Acinetobacter calcoaceticus*.

ANAEROBES: Bacteroides species, *Clostridium* species (Note: most strains of *C difficile* are resistant).

SUSCEPTIBILITY TESTING: Standard susceptibility disk method. Quantitative methods that require measurement of zone diameters give the most precise estimate of antibiotic susceptibility. One such procedure (Bauer AW, Kirby WMM, Sherris JC, Turck M: Antibiotic Susceptibility Testing by a Standardized Single Disk Method, *Am J Clin Pathol* 45: 493-496, 1966; Standardized Disk Susceptibility Test, *Federal Register* 39: 19182-19184, 1974, National Committee for Clinical Laboratory Standards, Approved Standard—ASM-2, Performance Standards for Antimicrobial Disk Susceptibility Tests, July 1975) has been recommended for use with disks to test susceptibility to ceftriaxone.

Laboratory results of the standardized single-disk susceptibility test using a 30-mcg ceftriaxone disk should be interpreted according to the following three criteria:

1. Susceptible organisms produce zones of 18 mm or greater, indicating that the tested organism is likely to respond to therapy.
2. Organisms that produce zones of 14 to 17 mm are expected to be susceptible if a high dosage (not to exceed 4 gm per day) is used or if the infection is confined to tissues and fluids (e.g., urine), in which high antibiotic levels are attained.
3. Resistant organisms produce zones of 13 mm or less, indicating that other therapy should be selected.

Organisms should be tested with the ceftriaxone disk, since ceftriaxone has been shown by *in vitro* tests to be active against certain strains found resistant to cephalosporin class disks.

Organisms having zones of less than 18 mm around the cephalothin disk are not necessarily of intermediate susceptibility or resistant to ceftriaxone.

Standardized procedures require use of control organisms. The 30-mcg ceftriaxone disk should give zone diameters between 29 and 35 mm, 22 and 28 mm and 17 and 23 mm for the reference strains *E coli* ATCC 25922, *S aureus* ATCC 25923 and *P aeruginosa* ATCC 27853, respectively.

DILUTION TECHNIQUES: Based on the pharmacokinetic profile of ceftriaxone, a bacterial isolate may be considered susceptible if the MIC value for ceftriaxone is not more than 16 mcg/ml. Organisms are considered resistant to ceftriaxone if the MIC is equal to or greater than 64 mcg/ml. Organisms having an MIC value of less than 64 mcg/ml, but greater than 16 mcg/ml, are expected to be susceptible if a high dosage (not to exceed 4 gm per day) is used or if the infection is confined to tissues and fluids (e.g., urine), in which high antibiotic levels are attained.

E coli ATCC 25922, *S aureus* ATCC 25923 and *P aeruginosa* ATCC 27853 are also the recommended reference strains for controlling ceftriaxone dilution tests. Greater than 95% of MICs for the *E coli* strain should fall within the range of 0.016 to 0.5 mcg/ml. The range for the *S aureus* strain should be 1 to 2 mcg/ml, while for the *P aeruginosa* strain the range should be 8 to 64 mcg/ml.

INDICATIONS AND USAGE: Rocephin is indicated for the treatment of the following infections when caused by susceptible organisms:

LOWER RESPIRATORY TRACT INFECTIONS caused by *Strep pneumoniae, Streptococcus* species (excluding enterococci), *Staph aureus, H influenzae, H parainfluenzae, Klebsiella* species (including *K pneumoniae*), *E coli, E aerogenes, Proteus mirabilis* and *Serratia marcescens*.

SKIN AND SKIN STRUCTURE INFECTIONS caused by *Staph aureus, Staph epidermidis, Streptococcus* species (excluding enterococci), *E cloacae, Klebsiella* species (including *K pneumoniae*), *Proteus mirabilis* and *Pseudomonas aeruginosa*.

URINARY TRACT INFECTIONS (complicated and uncomplicated) caused by *E coli, Proteus mirabilis, Proteus vulgaris, M morganii* and *Klebsiella* species (including *K pneumoniae*).

UNCOMPLICATED GONORRHEA (cervical/urethral and rectal) caused by *Neisseria gonorrhoeae*, including both penicillinase and nonpenicillinase producing strains.

PELVIC INFLAMMATORY DISEASE caused by *N gonorrhoeae*.

BACTERIAL SEPTICEMIA caused by *Staph aureus, Strep pneumoniae, E coli, H influenzae* and *K pneumoniae*.

BONE AND JOINT INFECTIONS caused by *Staph aureus, Strep pneumoniae, Streptococcus* species (excluding enterococci), *E coli, P mirabilis, K pneumoniae* and *Enterobacter* species.

INTRA-ABDOMINAL INFECTIONS caused by *E coli* and *K pneumoniae*.

MENINGITIS caused by *H influenzae, N meningitidis* and *Strep pneumoniae*. Ceftriaxone has also been used successfully in a limited number of cases of meningitis and shunt infections caused by *Staph epidermidis* and *E coli*.

PROPHYLAXIS: The administration of a single dose of ceftriaxone preoperatively may reduce the incidence of postoperative infections in patients undergoing coronary artery bypass surgery.

Although ceftriaxone has been shown to have been as effective as cefazolin in the prevention of infection following coronary artery bypass surgery, no placebo-controlled trials have been conducted to evaluate any cephalosporin antibiotic in the prevention of infection following coronary artery bypass surgery.

SUSCEPTIBILITY TESTING: Before instituting treatment with Rocephin, appropriate specimens should be obtained for isolation of the causative organism and for determination of its susceptibility to the drug. Therapy may be instituted prior to obtaining results of susceptibility testing.

CONTRAINDICATIONS: Rocephin is contraindicated in patients with known allergy to the cephalosporin class of antibiotics.

WARNINGS: BEFORE THERAPY WITH ROCEPHIN IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS, PENICILLINS OR OTHER DRUGS. THIS PRODUCT SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. ANTIBIOTICS SHOULD BE ADMINISTERED WITH CAUTION TO ANY PATIENT WHO HAS DEMONSTRATED SOME FORM OF ALLERGY, PARTICULARLY TO DRUGS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE THE USE OF SUBCUTANEOUS EPINEPHRINE AND OTHER EMERGENCY MEASURES.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad-spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.

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Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind to the toxin *in vitro*.

Mild cases of colitis respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated.

When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: *GENERAL:* Although transient elevations of BUN and serum creatinine have been observed, at the recommended dosages, the nephrotoxic potential of Rocephin is similar to that of other cephalosporins.

Ceftriaxone is excreted via both biliary and renal excretion (see Clinical Pharmacology). Therefore, patients with renal failure normally require no adjustment in dosage when usual doses of Rocephin are administered, but concentrations of drug in the serum should be monitored periodically if evidence of accumulation exists; dosage should be decreased accordingly.

Dosage adjustments should not be necessary in patients with hepatic dysfunction, however, in patients with both hepatic dysfunction and significant renal disease, Rocephin dosage should not exceed 2 gm daily without close monitoring of serum concentrations.

Alterations in prothrombin times have occurred rarely in patients treated with Rocephin. Patients with impaired vitamin K synthesis or low vitamin K stores (e.g., chronic hepatic disease and malnutrition) may require monitoring of prothrombin time during Rocephin treatment. Vitamin K administration (10 mg weekly) may be necessary if the prothrombin time is prolonged before or during therapy.

Prolonged use of Rocephin may result in overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Rocephin should be prescribed with caution in individuals with a history of gastrointestinal disease, especially colitis.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Carcinogenesis: Considering the maximum duration of treatment and the class of the compound, carcinogenicity studies with ceftriaxone in animals have not been performed. The maximum duration of animal toxicity studies was six months.

Mutagenesis: Genetic toxicology tests included the Ames test, a micronucleus test and a test for chromosomal aberrations in human lymphocytes cultured *in vitro* with ceftriaxone. Ceftriaxone showed no potential for mutagenic activity in these studies.

Impairment of Fertility: Ceftriaxone produced no impairment of fertility when given intravenously to rats at daily doses up to 586 mg/kg/day, approximately 20 times the recommended clinical dose of 2 gm/day.

PREGNANCY: Teratogenic Effects: Pregnancy Category B. Reproductive studies have been performed in mice and rats at doses up to 20 times the usual human dose and have no evidence of embryotoxicity, fetotoxicity or teratogenicity. In primates, no embryotoxicity or teratogenicity was demonstrated at a dose approximately three times the human dose.

There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproductive studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nonteratogenic Effects: In rats, in the Segment I (fertility and general reproduction) and Segment III (perinatal and postnatal) studies with intravenously administered ceftriaxone, no adverse effects were noted on various reproductive parameters during gestation and lactation, including postnatal growth, functional behavior and reproductive ability of the offspring, at doses of 586 mg/kg/day or less.

NURSING MOTHERS: Low concentrations of ceftriaxone are excreted in human milk. Caution should be exercised when Rocephin is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness of Rocephin in neonates, infants and children have been established for the dosages described in the Dosage and Administration section.

ADVERSE REACTIONS: Rocephin is generally well tolerated. In clinical trials, the following adverse reactions, which were considered to be related to Rocephin therapy or of uncertain etiology, were observed:

LOCAL REACTIONS—pain, induration or tenderness at the site of injection (1%). Less frequently reported (less than 1%) was phlebitis after IV administration.

HYPERSENSITIVITY—rash (1.7%). Less frequently reported (less than 1%) were pruritus, fever or chills.

HEMATOLOGIC—eosinophilia (6%), thrombocytosis (5.1%) and leukopenia (2.1%). Less frequently reported (less than 1%) were anemia, neutropenia, lymphopenia, thrombocytopenia and prolongation of the prothrombin time.

GASTROINTESTINAL—diarrhea (2.7%). Less frequently reported (less than 1%) were nausea or vomiting, and dysgeusia.

HEPATIC—elevations of SGOT (3.1%) or SGPT (3.3%). Less frequently reported (less than 1%) were elevations of alkaline phosphatase and bilirubin.

RENAL—elevations of the BUN (1.2%). Less frequently reported (less than 1%) were elevations of creatinine and the presence of casts in the urine.

CENTRAL NERVOUS SYSTEM—headache or dizziness were reported occasionally (less than 1%).

GENITOURINARY—moniliasis or vaginitis were reported occasionally (less than 1%).

MISCELLANEOUS—diaphoresis and flushing were reported occasionally (less than 1%).

Other rarely observed adverse reactions (less than 0.1%) include leukocytosis, lymphocytosis, monocytosis, basophilia, a decrease in the prothrombin time, jaundice, glycosuria, hematuria, bronchospasm, serum sickness, abdominal pain, colitis, flatulence, dyspepsia, palpitations and epistaxis.

DOSAGE AND ADMINISTRATION: Rocephin may be administered intravenously or intramuscularly. The usual adult daily dose is 1 to 2 gm given once a day (or in equally divided doses twice a day) depending on the type and severity of the infection. The total daily dose should not exceed 4 grams.

For the treatment of serious miscellaneous infections in children, other than meningitis, the recommended total daily dose is 50 to 75 mg/kg (not to exceed 2 grams), given in divided doses every 12 hours.

Generally, Rocephin therapy should be continued for at least two days after the signs and symptoms of infection have disappeared. The usual duration is 4 to 14 days; in complicated infections longer therapy may be required.

In the treatment of meningitis, a daily dose of 100 mg/kg (not to exceed 4 grams), given in divided doses every 12 hours, should be administered with or without a loading dose of 75 mg/kg.

For the treatment of uncomplicated gonococcal infections, a single intramuscular dose of 250 mg is recommended.

For preoperative use (surgical prophylaxis), a single dose of 1 gm administered ½ to 2 hours before surgery is recommended.

When treating infections caused by *Streptococcus pyogenes*, therapy should be continued for at least ten days.

No dosage adjustment is necessary for patients with impairment of renal or hepatic function, however, blood levels should be monitored in patients with severe renal impairment (e.g., dialysis patients) and in patients with both renal and hepatic dysfunctions.

HOW SUPPLIED: Rocephin (ceftriaxone sodium/Roche) is supplied as a sterile crystalline powder in glass vials and piggyback bottles. The following packages are available:

Vials containing 250 mg equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1962-01)

Vials containing 500 mg equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1963-01)

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Piggyback bottles containing 1 gm equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1964-03)

Vials containing 2 gm equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1965-01)

Piggyback bottles containing 2 gm equivalent of ceftriaxone: Boxes of 10 (NDC 0004-1965-03)

Bulk pharmacy containers, containing 10 gm equivalent of ceftriaxone: Boxes of 1 (NDC 0004-1971-01)

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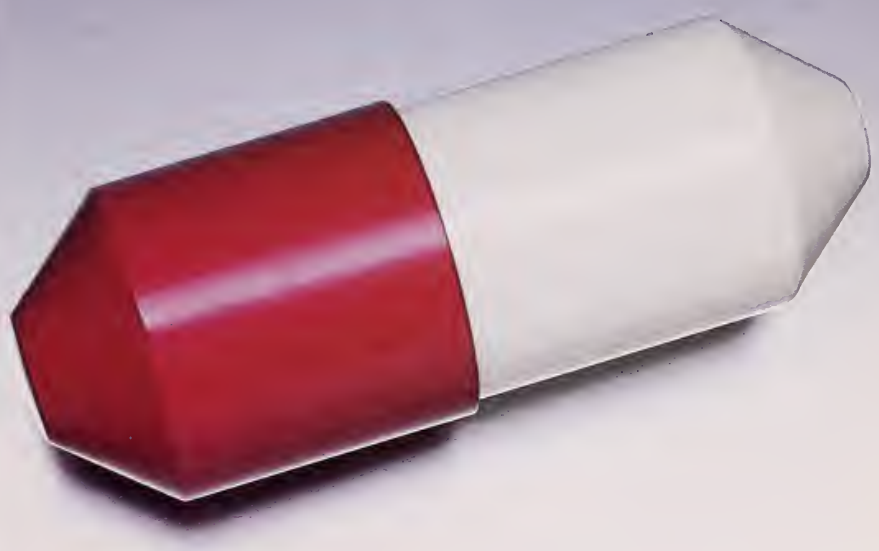
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* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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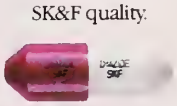
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J-6138 January 1986



ZOVIRAX®
(acyclovir)
CAPSULES

Prevent genital herpes recurrences month after month with daily therapy.

(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)

Please see last page of this advertisement for brief summary of prescribing information.

ZOVIRAX®
(acyclovir)
CAPSULES

Help free your patients from recurrences.

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks — month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

Please see brief summary of prescribing information on next page.



Prevent recurrences month after month*

ZOVIRAX®
(acyclovir)
CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies,. the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤10 ml/min/1.73/m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200"- Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

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To find out about the benefits of serving with a nearby Army Reserve unit, we recommend you call our Army Medical Personnel Counselor.

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One, time. We know how tough it is for a busy physician to make weekend time commitments. So we offer flexible training programs that allow a physician to share some time with his or her country. We arrange a schedule to suit your requirements.

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Mythology of excess health care utilization:

Tale of Blue Cross-Blue Shield guidelines for laboratory and other diagnostic procedures

The Board of Regents of the American College of Physicians and Blue Cross-Blue Shield have collaborated to develop a list of indications for certain laboratory and diagnostic procedures. The list has been submitted for comment to medical societies throughout the United States. The recommendations come lacquered with a seductive glaze that they are "broad guidelines" rather than specific criteria or indications for the procedures.

It is hard to accept that the Board of Regents of the American College of Physicians would lend its stature to such an obvious regulatory gambit. Either the members of the Board of Regents are suffering from a frosting-over of their frontal lobe synaptic linkages, or they have not had to deal with the perfidy of the myxedematous myrmidons who populate the reimbursement departments of Medicare, Workmens' Compensation, the PRO, and other third-party payers. The designers of the draft proposals may think that they have assembled a collation of recommendations that provide the practitioner with broad powers of individual judgments; we can wager, however, with nearly 100% certainty, that the future consequences of the adoption of this list of recommendations will be wholesale disallowances of payments for laboratory procedures, electrocardiograms, chest x-rays, etc., and the imposition of an additional burden of unneeded chart documentation.

The difficulty is that, once again, American doctors are being required to sacrifice their own clinical skills and judgment to the exigencies of cost containment. William Osler emphasized that clinical decisions about patient management could be rendered only at the bedside; yet his wisdom is being revised by regulators who wish to remove patient care decision making to a remotely located computer terminal.

Blue Cross-Blue Shield contends that too many diagnostic procedures are being performed in the inpatient and outpatient spheres of medical care and that several billion dollars can be "saved" by implementation of the new guidelines. The evidence of overuse of diagnostic and therapeutic procedures in the medical care system is thin, if not nonexistent. The panderers of the "waste in medicine" theme claim that 25-30% of medical care in the United States is unnecessary and that regulatory necromancy can conjure up significant cost savings for government and the insurance industry.

The concept that there is excess utilization of the health care system is fallacious. The observation that leads to the fallacy is that there is significant variation in the use of diagnostic and therapeutic services among geographically different populations.

The concept that there is excess utilization of the health care system is fallacious. The observation that leads to the fallacy is that there is significant variation in the use of diagnostic and therapeutic services among geographically different populations. These variations may be large. For instance, procedure X may be performed six times more commonly in community A than in community B. The decerebrate, interpretive reaction to this observation is that procedure X is over-utilized in community A. Reduce the rate of utilization in procedure X in community A to that of community B, and you will save many health care resource dollars. One does not require the academic

trappings of a logician to recognize there are other alternative interpretations to these data. However, the existence of other interpretations (such as procedure X may be under-utilized in community B, or that community B lacks the physicians or hospital resources to perform procedure X, or that patients may not be able to afford procedure X) has been relegated to the dust bin of nonreality by many medical economists.

Wennbern and Gittelsohn have published widely on the geographic variations in the rates of performances of surgical procedures and in the per capita costs of medical care that exist among 193 hospital treatment areas in New England.[1, 2] The rates in geographic areas where hysterectomies and prostatectomies were most commonly performed were four times the lowest rates; for tonsillectomies, the highest rate was six times the lowest rates. In 1975, inpatient hospital treatment per capita was $324 in Boston but only $120 in Hanover, New Hampshire. On the surface, these large differences in utilization might suggest that over-utilization in medical services is rampant in certain parts of American society and that corrective action is critically required.

Helen Smits has commented that "a primary regulatory response to Wennberg's elegant work is dangerous and irresponsible."[3] Utilization rate variation may uncover some over-utilization in isolated instances. However, there are more compelling alternative explanations for regional variations in procedure performance.

The first explanation is that scientific uncertainty abounds within medicine as to the greater propriety of one treatment versus another for the management of a given disease. Rutland, Zuidema, and Gittelsohn[4] surveyed a random sampling of surgeons about the indication for a specific surgical procedure in the treatment of three fictitious cases. A vast divergence of opinion was obtained. Similarly, there are differences of opinion as to the best means of treating angina: some cardiologists feel that a purely medical and pharmacological approach is proper; a second, equally qualified group favors bypass surgery. The need for hospitalization for certain disease treatments is also controversial. For instance, rheumatoid arthritis patients benefit from 10-14 days of inpatient hospitalization, and some rheumatologists routinely hospitalize their patients who suffer acute flares of other disease or whose disease remains persistently active. Other rheumatologists rarely hospitalize these patients. The differences of opinion are not provoked by differences in physicians' titer of avariciousness or ignorance or inflexible commitment to a set practice style. The variations result from lack of research data that compare the long-term biologic and economic outcomes of available alternative therapies currently acceptable for the management of a given disease. The peer review processes of the 1970s and 1980s have clearly demonstrated that the overwhelming majority of physicians practice in the best interest of their patients' health and quality of life and within the confines of a well-defined corridor of acceptable medical practice.

A second reason for geographic variation and utilization of medical services is the lag time in the application and acceptance of new diagnostic or treatment approaches to a given disease. New technologies or treatments may be initiated at academic centers and then gradually seep into the practices of physicians across the country. Younger doctors adopt new technology sooner than older ones. Differences in the availability of hospital and professional capital will alter the adoption of new technology. For instance, MRI has been available for several years but has only recently become available to most communities. Geographic areas that lack a cardiac surgeon will obviously express low rates of surgical treatment of coronary heart disease. Improvements in the technology of delivery of some service may increase the indication for that service: 20 years ago, cataract extraction was delayed until the patient's vision deteriorated severely. Technical innovations in this type of surgery have made this procedure safe, more predictable in its outcome, more effective, and less traumatic to the patient so that earlier intervention and an improved quality of life can now be provided. Cataract surgery is, therefore, more commonly performed today than it was two decades ago.

Variations in geographic utilization of health care services provide feeble, if any, support for the hypothesis that significant abuse and utilization of health care services exist. Wise policy makers would search for other data to confirm and measure over-utilization before imposing restrictions on the health care system.

Geographic variations are also seen in the rates of performance of procedures that are most unlikely to be over-utilized, such as bilateral nephrectomy. The differences in nephrectomy performance are obviously due to the availability of a dialysis or renal transplant program within the community.[3] Thus, variations in the dissemination of technology account for a significant proportion of the geogrphic variations in health care utilization. The evaluation of a new technology must be based on long-term outcome studies. Technological innovations must not, a priori, be accepted as desirable or similarly rejected as wasteful.

A third explanation for the geographic variations in health care consumption is the variation in the health status of the surveyed populations. For instance, chronic obstructive pulmonary disease and

lung cancer are more prevalent among coal miners. Multiple sclerosis occurs nearly twice as commonly among people living above than those living below the 37th parallel.

The economic resources of the population will also dictate use of health care. Utilization of services will increase if services are free but decrease if co-payments for services are large. Regulatory and insurance companies have snatched this finding from the Rand study and have adopted it as the doctrinal rationale to demand increasing co-payments by health care consumers in an effort to reduce utilization. Utilization will recede with large co-payments but, if one spins his focus onto the obverse side of the issue, one would ask if the large co-payments and decreased utilization deter patients from receiving necessary care. Would under-utilization now, such as decreased treatment for blood pressure, result in greater societal costs in terms of strokes, renal disease, and heart failure in later years?

Thus, variations in geographic utilization of health care services provide feeble, if any, support for the hypothesis that significant abuse and utilization of health care services exist. Wise policy makers would search for other data to confirm and measure over-utilization before imposing restrictions on the health care system. Applying economic or punitive measures to providers or consumers in a system in which significant over-utilization is lacking will simply disrupt the quality of the care and ultimately lead to significant decline in the nation's health.

Is there data for over-utilization from other sources? Not according to other studies.

Over-utilization of the health care system is probably economically insignificant. There is a glaring lack of support for the Blue Cross-Blue Shield contention that over-utilization exists for the procedures listed in their current recommendations. If over-utilization does not exist, why impose guidelines on the use of these procedures?

Perrin and Valvona[5] examined the impact of physicians' supply and utilization of services. They measured the numbers of physician visits and the diagnostic and therapeutic procedures performed by a cross section of private practice physicians surveyed by University of Southern California between 1976 and 1978 and assayed the frequency of inappropriate testing by standards of care developed by other investigators. They found that "for all diagnoses, the number of tests ordered was consistenly low." Only 5% of tests or procedures were considered inappropriate. More surprisingly, the number of tests did not rise with physician supply increase.

Showstack, Stone, and Schroeder reviewed records of patients hospitalized in 1972, 1977, and 1982 and found that laboratory tests and similar small ticket items did not contribute to the rising health care costs.[6] Neither did new imaging procedures since such procedures replaced other, more invasive, and more expensive procedures. Increased health care costs were attributed to the increased performance of cardiac surgery and coronary artery disease and increased amounts of intensive care for newborns and the critically ill.

Mitchell and Virts remind us of the studies that show that a disproportionate amount of health care is consumed by a small percentage of the population.[7] Nine percent of Medicare enrollees consume 81% of the Part A reimbursement. One employer found that 10% of its employees consumed two thirds of its total health spending. To reduce health expenditures by 25% would cause significant hardship for all, yet reduce total costs by only 8% in that 90% of the population that consumes only 33% of the health care resources: would that 8% reduction in health care costs justify the potential long-term negative effects on society's health, i.e., in terms of the reduction in prevention of illness or in the prevention of loss of productive employment, in the increased morbidity and mortality, and in the loss of quality of life? Mitchell and Virts think not. They feel that waste in the health care system is grossly overestimated. The Rand Health Insurance Experiment reported last year that "we could find little or no evidence of gross overuse of office visits, diagnostic tests, procedures or the like in the production of an ambulatory episode of care. There does not appear to be much slack in ambulatory care, [and] certainly not enough to improve the efficiency of medical practice along these lines."[8]

It appears to this reviewer that over-utilization of the health care system is probably economically insignificant. There is a glaring lack of support for the Blue Cross-Blue Shield contention that over-utilization exists for the procedures listed in its current recommendations. If over-utilization does not exist, why impose guidelines on the use of these procedures? There can be but two reasons: either (1) Blue Cross-Blue Shield officials and the Board of Regents of the American Board of Internal Medicine are misguided or ignorant, or (2) Blue Cross-Blue Shield is bloating the over-utilization theory as a subterfuge to allow its reviewers to arbitrarily deny payment for diagnostic procedures that may be medically justified, thereby hoping to improve its own profitability and competitiveness in the health care insurance industry. Clerical and administrative costs to providers to defend the utilization of these small ticket items will exceed the amount of income to be derived from any of these procedures; however, the aggregate costs of

multiple denials can become staggering.

If Blue Cross-Blue Shield was sincere in eradicating only the waste (which is virtually nonexistent in the published studies), would the extra administrative cost burden to Blue Cross-Blue Shield and to suppliers justify the imposition of this extra layer of bureaucratic mischief? I think not.

Hopefully, representatives of the pathologists, hospitals, and primary care physicians will unlease an apoplexy of protest against the imposition of these guidelines. Perhaps the internists can alter the opinions of their misguided Board of Regents. The leaders of the Florida Medical Association should express their displeasure to the American Medical Association and arouse the Florida membership to unite against imposition of these guidelines.

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Daytona Beach



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NOTES & NEWS

Congenital syphilis in Florida

Since 1983, Florida has experienced sharp increases in the number of reported cases of early congenital syphilis diagnosed in the state. The number increased 222% in 1986 alone, to 100 cases. A review of these cases, including 24 which ended in fetal or infant death, indicated that the majority of the women in Florida who delivered infants with signs or symptoms of congenital syphilis did not seek prenatal care which might have prevented the often tragic consequences of syphilis in pregnancy.

It is well known that increases in the number of cases of early infectious (primary and secondary) syphilis, especially among women, predict a subsequent increase in early congenital syphilis. Since 1979, both the national and Florida case rates for early infectious syphilis have risen. In 1980, the Florida case rate of 23.2/100,000 population ranked as the fifth highest in the United States. Since 1980, Florida has steadily climbed in rank until, in 1984, the Florida case rate of 35.6/100,000 population was the highest in the nation (Table 1). Case rates for all states for 1985 and 1986 have not yet been published, but it is thought that the Florida case rate for early infectious syphilis remains among the highest in the nation.

Table 1.—Early Infectious Syphilis Case Rates/100,000 Population.

	1979	1980	1981	1982	1983	1984	1985	1986
U.S.	11.2	12.1	13.7	14.6	14.1	12.2	11.5	11.3
Florida	24.0	23.2	30.1	40.2	39.5	35.6	32.6	37.6
Ranks Among All States		5th	4th	3rd	2nd	1st	N/A	N/A

Between 1982 and 1983, the number of reported cases of congenital syphilis in Florida tripled (8 cases in 1982 vs 25 cases in 1983); 30 cases reported in 1984, 31 cases in 1985, and 100 cases in 1986. The case rates for congenital syphilis for Florida and the United States as a whole have risen dramatically since 1983, as Table 2 illustrates.

Table 2.—Congenital Syphilis Case Rates per 1,000 Live Births in Florida and the U.S.

	1979	1980	1981	1982	1983	1984	1985	1986
U.S.·	3.2	3.1	3.7	4.8	3.5	5.5	8.2	N/A
Florida··	5.8	2.3	5.1	5.5	16.8	19.3	18.9	31.6···

· Fiscal Year
·· Calendar Year
···January-June 1986

A review of the 100 cases of congenital syphilis reported for 1986 reveals that 78% (78) of the cases were reported from Jackson Memorial Hospital in Dade County and Broward General Medical Center in Broward County. In fact, 80% of reported cases reside in either Dade or Broward County. Eighty-eight percent (88%) of the cases are black, 87% of the mothers are unmarried. The ages of the mothers range from 15-38 years, with a mean age of 24.3. Sixty-five percent (65%) of the mothers received no prenatal care prior to delivery; of those who did receive at least one prenatal exam (35), 51.4% (18) waited until the 26th week of pregnancy or later to do so (Table 3). Thirty-seven percent (13) of the infected mothers who received at least one prenatal exam had a nonreactive serologic test for syphilis at first exam, yet subsequently developed syphilis. Twenty three of the women who were seen during pregnancy were treated for syphilis during their pregnancies. Eighty-three percent of these (19) received benzathine penicillin; 17% (4) received erythromycin. Five of 23 (21.2%) suffered fetal demise between one and 21.5 weeks (mean 9.8) after beginning therapy. In all, 24 (24%) of the 100 pregnancies ended in fetal death or infant death.

Table 3.—Clinical Status of Congenital Syphilis Reported in Florida in 1986.

N=100	No. of Women	Percent
Did not receive prenatal care	65	65%
Did receive prenatal care	35	35%
First visit 26 weeks or later	18	51.4%
Negative STS at first visit	13	37.1%
Pregnancies ending in fetal death, stillbirth or infant death	24	24%

A review of these cases emphasizes the importance of early, appropriate and continuous prenatal care in preventing congenital syphilis. Clinicians should perform a serologic test for syphilis (STS) at both the first and third trimester (especially for high-risk mothers). Women who deliver without evidence of two negative serologic test during preganancy, and women who have a history of a reactive test, should be evaluated and treated for syphilis according to the

criteria discussed in the Centers for Disease Control's *1985 STD Treatment Guidelines*. Mothers and infants treated for syphilis will require periodic serologic evalutaion to ensure cure. For additional information or assistance, physicians should contact their local county public health unit or call the State Epidemiologist at (904) 487-2542.

USF names vice president for health sciences

Ronald P. Kaufman, M.D., vice president for medical affairs and executive dean of the George Washington University Medical Center, has been appointed vice president for health sciences at the University of South Florida, President John Lott Brown announced early in May.

Selected from a national pool of candidates, Dr. Kaufman assumes his new position on September 1. He will succeed Donn L. Smith, M.D., who has been serving as interim vice president of medical affairs since June 1986.

In making the announcement, President Brown referred to Dr. Kaufman's outstanding record as a physician, medical educator and administrator.

"For over three decades, he has dedicated his life to the field of medicine," President Brown said. "His experience includes clinical practice, teaching, research and administration. Of utmost importance to our particular needs, he has been acknowledged by leaders in health sciences for his philosophy and a style of medical and health science administration that will be immensely beneficial for the medical program at USF.

"Dr. Kaufman is coming to us from a university located in the large metropolitan area of Washington, D.C. Thus, he will bring experience of inestimable value in furthering our program in the metropolitan Tampa Bay region."

From his home in Bethesda, MD., Dr. Kaufman recalled his recent visit to USF and his perception at that time that the USF Medical Center has "tremendous potential" to become one of the nation's best.

"The USF medical program is young, vibrant and is growing at a fantastic rate," he said. "I welcome the opportunity to share in the excitement, help shape the future, work with colleagues to produce outstanding practitioners, and assist in the national effort to find remedies and cures for the medical ills that beset us."

T. Terrell Sessums, Chairman of the Florida Board of Regents, said of Dr. Kaufman, "He is an extremely well-qualified and experienced medical educator and administrator who can provide USF with strong leadership to continue the quality development of its medical education, research and public service programs.

"I am delighted that he has accepted the University's offer to become the chief executive officer of the health sciences," Regent Sessums said.

Dr. Charles B. Reed, Chancellor of the State University System of Florida, said, "Dr. Kaufman is a medical leader with a strong national reputation for excellence. He is precisely what USF needs at this time. We are fortunate to have him join our team."

"Dr. Kaufman will help to improve the already outstanding USF Medical Center, strengthen community relations and build on the important existing affiliations which USF has established throughout the Tampa Bay area," Chancellor Reed said.

Dr. Kaufman has been at the George Washington University since 1970 and has held the following positions: medical director of the University Hospital, associate dean for clinical affairs, dean for clinical affairs, and acting vice president for medical affairs. He is currently the Walther A. Bloedorn Professor of Administrative Medicine and Professor of Medicine at the University

An accomplished writer and public speaker, Dr. Kaufman has authored or co-authored numerous articles for professional journals and has made many presentations to groups ranging from Trustees of the Harvard Medical Center to the Association of American Medical Colleges.

He currently serves as chairman of the board of directors of the Association of Academic Health Centers and has served as president of the American College of Physician Executives. He is a member of the American Society of Internal Medicine and the Association of American Medical Colleges and holds appointments in the National Institutes of Health and the National Association of Biomedical Research.

Dr. Kaufman is a 1951 graduate of Trinity College (Hartford, CT) where he was inducted into Phi Beta Kappa. He received his M.D. degree from the University of Pennsylvania School of Medicine in 1955. He interned and did his residency in internal medicine at Hartford Hospital. He also served two years as a physician in the U.S. Air Force Medical Corps.

Warren Ross, M.D., receives Hippocratic award

Warren Ross, M.D., Associate Professor of Medicine, Pharmacology and Therapeutics at the University of Florida College of Medicine, has received the 1987 Hippocratic Award for Teaching Excellence, the highest honor bestowed upon a faculty member by the graduating seniors of the UF College of Medicine.

The award, established by the 1969 medical class, is given to the faculty member whom students feel "best exemplifies the ideals of Hippocrates in compassionate patient care and effective teaching." Hip-

pocrates is believed to have lifted medicine from speculation and superstition to an organized, investigative profession.

In presenting the award, Gregory Waller, senior awards committee chairman, said Dr. Ross "is a unique physician who dares to challenge where there is doubt; who not only encourages compassion, but demonstrates compassion. He is a man who has not only imparted knowledge, but has taught us a way of thinking.

"We shall always remember him. The details will pass away, but the knowledge, inspiration and the challenge to think will always remain." Presenting the award with Waller were Manny Padron, president of the 1987 class, and Patti Dolan, a member of the senior awards committee.

The Hippocratic Award follows many other awards Dr. Ross has earned over the course of his career. His teaching excellence was honored in 1986 when he was named Teacher of the Year in the College of Medicine, in 1984 as Outstanding Basic Science Instructor, and in 1983 as Outstanding Clinical Instructor. He also was the 1985 commencement speaker for both the University of Florida and the College of Medicine.

Dr. Ross earned his medical degree from UF in 1973, after which he worked as a clinical associate and senior investigator at the National Cancer Institute at the National Institutes of Health (NIH). He returned to UF in 1978 to join the medical faculty. He currently is the principal investigator of a four-center research team established to develop new anti-cancer drugs. The project is supported by a $2.7 million grant from NIH.

ACCME awards FMA maximum continued recognition

The Committee for Review and Recognition of the Accreditation Council for Continuing Medical Education (ACCME) conducted an on-site survey of FMA policies and procedures for the accreditation of intrastate sponsors of CME on November 21, 1986. Based on the survey results, the ACCME on May 14, 1987 awarded the FMA Committee on Medical Education, Orris O. Rollie, M.D., Chairman, the maximum four year period of continued recognition.

Howard S. Madigan, M.D., Chairman of the Committee for Review and Recognition, reported the ACCME is encouraged by the high quality of effort and interest displayed by the FMA in its accreditation program. The FMA currently accredits 24 intrastate sponsors of CME under the direction of the Committee on Medical Education. Each accredited sponsor must adhere to seven Essentials which ensure quality continuing medical education programs, according to Pierre J. Bouis Jr., M.D., Chairman of the Council on Scientific Activities.

DEAN'S MESSAGE

Go forth and do good

Once again those of us who work in the field of medical education have sent forth this year's group of medical school graduates. These young people have been processed, matched for residency training, and exhorted by prestigious commencement speakers to become caring, professionally competent providers of health care.

At this point two important questions arise in the minds of conscientious educators. First, is the educational process indeed providing the appropriate background and motivation for our graduates? Secondly, in terms of the ever-changing societal need and expectations, what of the presumably bright and challenging future which we have always presumed to belong to those who achieve admission to and complete the courses of study leading to the award of the medical degree?

As one considers the question of competence in the process of medical education, several issues become visible. The typical medical school curriculum contains exposure to massive amounts of ever-increasing scientific based knowledge which is highly relevant to the conduct of effective medical care. To further complicate matters, an unknown portion of the information presented will fall into obsolescence prior to the emergence of the student as a physician. In addition, other kinds of information are increasing in importance relative to the prospective physician's future activities. Computer competency, fiscal information relative to the new economics of health care, knowledge of the proliferating alphabet of HMO, PPO, etc., and the implication of these organizations as their implementation affects the practice of medicine. Also are added new disease entities, and malpractice problems. In order to provide exposure to all of the information which now bears on medical practice, within an already hectic and difficult four year period, selection of the material that must remain and that which must be removed from the curriculum presents a difficult problem for the curriculum committees. Instruction in the areas of bioethics and the humanistic elements of medicine including geriatrics are also involved in the competition for time and resource which pervades the fiscal and educational elements of the educational operation. As we proceed towards the solutions for these problems, the medical student as a hard-working, well-motivated human being must be considered as the primary asset in the total process. The potential for inadvertent or unrecognized overload applied to the physical and mental resources of the student

represents a real danger to the welfare of all concerned. No one advocates the production of exhausted, confused and motivationally deprived new physicians, although there is some feeling that this may indeed be taking place in some cases.

Now to the prospects of the future for our graduates. Until recently a solid financial affluence was a given for practically every graduate. New and significant developments which are appearing may require that the new graduate consider the desirability of primary care versus subspecialization, corporate employment versus fee for service. Consideration of private practice and whether or not certain malpractice costs will be acceptable as specialty type practice will occur.

Some of the operative forces may make it possible for a more reasonable type of lifestyle, with more time available for family, hobbies and relaxation. These prospective benefits will in all probability relate to decreased income.

We all hope that whatever the shape and form of the final medical practice equation, our young colleagues will continue to enjoy the excitement and challenge of the physician — patient relationship, with equanimity and financial health consistent with the time and effort expended to obtain medical education and the expertise which they will provide.

Those of us engaged in the difficult but rewarding task of providing medical education will continue to do our best to fit the physician's education to the needs engendered by the societal forces now shaping the practice of medicine.

We all hope that our young proteges will continue, as in the past, to be warmly welcomed by the practicing community.

The problems that will face the newly educated, residency trained physician are unique to the times and the understanding and support of their older, wiser colleagues will undoubtedly be greatly appreciate.

Donn L. Smith, M.D., Ph.D.
Interim Vice President and Dean
University of South Florida
College of Medicine

ENCORES!

Physician entrepreneurs

Do they shortchange their patients?

George Eliot, who wrote, "May I reach the purest heaven,—be to her souls the cup of strength in some great agony," also once said, "I acknowledge myself to be a very sordid author with some love for money as well as for mankind." Would she or could she have made such an admission as a physician? How do love of money and love of humankind square off in medicine?

Over the past decade, several trends developed that are bringing the delicate issue of profits in health care to the forefront for many physicians, particularly those contemplating private practice. First, the number of practicing physicians is growing more rapidly than the American population because of the doubling of capacity in U.S. medical schools between 1965 and 1980. By 1990, there should be forty-three percent more practicing physicians than there were in 1978, whereas the projected population increase is only fourteen percent. Further stimulants for profit-consciousness have been the advent of prospective payment, the emergence of a medical-industrial complex, and the development of HMOs, PPOs, and other alternative forms of health-care delivery. And to top it off, today's medical student enters a career with an average educational debt of approximately $30,000.

"Doctors are running scared," says Michael Greenwald, a Boston dermatologist and entrepreneur. "A lot of them are coming to the realization that, 'My God, I am faced with HMOs all around me. I am faced with a diminishing income. What do I do?' "

What some doctors are doing is starting their own health-care related businesses on the side, selling their expertise to for-profit firms, or investing in for-profit health-care facilities. This practice has given rise to the concern that their ethical imperative—to do what is best for the patient—may be unduly jeopardized because of an economic interest in the services or products they are in a position to recommend.

The bitter debate ● The issue of conflicts of interest in this context made its Massachusetts debut in July 1971, when the *Boston Globe* reported that a group of doctors at the Peter Bent Brigham hospital (now part of Brigham and Women's Hospital) was operating a profit-making artificial kidney center in Brookline, under the umbrella of the Brigham. One of the first of its kind in the nation, the Babcock Center offered outpatient dialysis for approximately half the cost levied by teaching hospitals such as the Brigham. The rub was this—Brigham doctors Constantine L. Hampers, William E. Hassan (then director of Peter Bent Brigham), and Edward B. Hager all owned stock in the Babcock Center's parent company (although Hassan relinquished his stock when the situation came to light) and were in a position to refer patients to their own outpatient facility. For this reason and others, the Massachusetts Department of Public Health declared the Babcock Center strictly illegal, triggering a bitter debate among physicians and public health officials.

When the *Globe* questioned Hampers, then chief of dialysis at the Brigham and medical director of the Babcock, about the possibility that his position as a referring physician at the Brigham might conflict with his financial interest, Hampers stated that he could not conceive of any possibility of a conflict, and said that any state involvement in the center was "obstructionist." "I don't know if the state department of public health would know an artificial kidney machine from a turnip," he told the *Globe*.

Today, Hampers maintains that "the *Globe* has and had a strong anti-proprietary medicine bias which was specifically levied against us during the early 1970s." Hampers emphasizes that two of his superiors, the director and the physician-in-chief of the Brigham's nephrology unit, had no economic interest in the Babcock, and therefore provided the essential element of peer review to the referral process. "With the proper controls and overview, physician involvement in proprietary medicine is not only desirable, but probably essential if the cost is to be controlled," Hampers says.

The legal issues surrounding the Babcock Center were eventually resolved, and despite early allegations of excessive profit margins, the center survived, and Hampers and some of this colleagues made the choice to give up their Brigham and Harvard Medical School appointments and go fully into the for-profit sector. Today, both the Babcock Artificial Kidney Center and its parent company, National Medical Care, are flourishing. They have made millions for the initial investors and provide outpatient dialysis for thousands of patients with end-stage renal disease.

For-profit organizations such as the Babcock Center have become more commonplace and are more widely accepted by the medical community than they were initially. In fact, Brigham and Women's Hospital now has a liaison with the for-profit Hospital Corporation of America, something that would have been unheard of ten years ago. Even at Harvard Medical School, it is not uncommon for faculty members to have interests in for-profit companies, as either investors or consultants.

However, the right of a practicing physician to engage in business activities that relate to patient care is still far from generally accepted. In fact, according to a 1984 American Medical Association survey, the majority of doctors are still uncomfortable with the idea. Sixty-five percent of the respondents answered yes when asked, "Do you believe it is a conflict of interest for physicians to refer patients to a hospital or other health-care facility in which they have an ownership incentive?"

Those opposed ● One of the strongest voices against medical entrepreneurialism is Arnold Relman, editor of the *New England Journal of Medicine*. Relman, who defines a medical entrepreneur as "a practicing physician who seeks to earn income or get capital gains from services which he, himself, does not directly provide or supervise," believes that the conflict of interest that arises in such situations makes it difficult for doctors to meet their ethical responsibilities. "In the long run, it is bad for the country and bad for the medical profession," Relman says.

Although Relman agrees that fee-for-service practice has always had a certain amount of inherent conflict of interest, he argues that medical entrepreneuralism compounds the problem and makes it even harder for the patient and the public to trust that the doctor is on their side. The doctor's primary role, Relman asserts, is to be an "incorruptible, honest fiduciary" and agent for the patient.

Leon Eisenberg, chairman of the Department of Social Medicine and Health Policy at Harvard Medical School, largely shares Relman's perspective. "Physicians should avoid investing in medical enterprises from which they then profit because, although they may not be aware of it consciously, it is hard to avoid sending your patients to the hospital, drug store, drug company, or whatever, in which you have a vested interest," Eisenberg believes. As he sees it, the doctor earns double profit on the patient—a fee for the service and a return for the referral—a set-up he likens to the now-illegal practice of fee-splitting.

The term "entrepreneur" has come to have a pejorative connotation in medicine, conjuring up the image of a greedy physician milking unnecessary profits out of sick people. This characterization is particularly deplored by physicians with business interests related to patient care—many of whom prefer not to be called entrepreneurs.

Those in favor ● "I disagree with the attitude that physicians with economic interests are less likely than their colleagues to have the best interests of their patients at heart," says Jeffrey Flier, director of the Diabetes and Metabolism Unit at Boston's Beth Israel Hospital. A discovery that Flier and his colleagues made—that insulin can be absorbed intra-nasally and that for some diabetics this may be a more effective route of insulin administration—is now being commercialized, and a nasal insulin spray, which Flier, his colleagues, and Beth Israel Hospital jointly patented, is being developed by Eli Lilly & Co.

"It [the nasal spray] has a certain efficacy, but it is definitely not a cure-all," Flier says. "If it does take off, one can imagine that three years from now we are going to be considered authorities in this area. We are going to be asked our opinion, we are going to be asked to write editorials, and since we also stand to gain from it there is an obvious potential conflict of interest." However, Flier feels strongly that in such situations, the public's and the medical community's strongest safeguards are the physician's honesty and integrity, and the arrangement being out in the open.

Michael Greenwald is another Massachusetts physician who has branched out into the for-profit sector. Greenwald, whose dermatology clinic is affiliated with New England Deaconess Hospital, manufactures its own line of skin-care products, which he sells to his patients. He maintains that this entreprise is directly related to patient care, that the products are not forced on the patients, and that the patients are not being "tricked" into supporting his cosmetics business because the products are clearly labeled with his name.

Conflict of interest? ● Greenwald sees no basic conflict between being a good doctor and also being a good businessman. In fact, he sees both as important for physicians today. "You can be the best doctor in the world, but if you can't pay your office rent, you can't see patients on the street," he remarks. Because of the competition from HMOs, doctors in private practice have to work much harder than they did ten years ago, Greenwald says, and this includes learning how to market themselves. "I sometimes wish I could go back to school and get an MBA from Harvard," says Greenwald, adding that he knows physicians who have done so after struggling unsuccessfully to set up a private practice. "The image of the doctor is not what it used to be, unfortunately. People are looking at medicine as more of a business today," he says, "and are as concerned about lower prices as about good medicine."

This perception is echoed by Harold Solomon, a hypertension expert with Brigham and Women's Hospital. "We gave people the best medicine available in the world, and now they are saying, 'we want the best, but it is too expensive.' " In response Solomon recommends that the health-care industry be opened up to competition; it must be organized and better distributed. He adds, "Medicine is no longer a pristine cottage industry. In fact, it never was. We were just very naive about it." Solomon has been involved in the development of health and weight-loss programs for hypertensives, and is a consultant for companies that manufacture blood-pressure equipment.

"Conflicts of interest are passe," Solomon says. In his opinion, the real issue is diminishing incomes for physicians, and what they are doing about it. Physicians who are roughly middle-aged enjoyed a fairly quick increase in their standard of living, Solomon suggests, because of an influx of insurance and Medicare reimbursement. "Now," he adds, "we are accustomed to a certain standard of living, and we are scraping around to maintain that living."

As for physicians' enterprises, Solomon worries not about doctors going into business on the side, but about doctors who bolster their income in unethical ways, such as abuses of the insurance system, Medicare fraud, faking test results, or prescribing unnecessary procedures. "There is no reason to fret if the patient's interest has been served," he says. It is unrealistic, he believes, to expect physicians who invent or develop a product just to turn it over to society.

George Blackburn, Director of the Nutrition Support Services at the New England Deaconess Hospital, says that his goal is not to make money but to facilitate the transfer of medical technology to health-care industries. Blackburn is on the board of directors of the Nutrition Research Center, a Boston-area business that uses many of the techniques he developed, and provides state-of-the-art treatment for morbid obesity. Although he refers patients to the Center, Blackburn stresses that he offers them a series of options, of which the Nutrition Research Center is only one. He also makes clear to patients his affiliation with the Center. Most of them do end up choosing the Center, however, which he says is probably because they trust him as their physician and because he is enthusaistic about this particular therapy program.

Like Solomon, Greenwald, and Flier, Blackburn does not think that conflicts of interest inherent in for-profit health care are any different from the "generic" conflicts of interest in medicine as a fee-for-service profession. "It is far better for doctors to focus on the generic issue of our professional code of ethics," he says, and calls entrepreneurial conflicts a trivial footnote. "Ninety percent of all physicians faced with a conflict of interest will act to minimize it or explain it so that there cannot be a misunderstanding," Blackburn says.

Code of ethics ● Disclosure of conflicts of interest is required for membership in the American Medical Association, and is thought by many physicians to be the key to resolving the ethical quandary that can arise in entrepreneurial endeavors that relate to patient care. But Arnold Relman looks at it differently. "First of all," Relman says, "disclosure is often more honored in the breach than the observance. . . . In my experience and in my opinion, very few doctors are totally forthright about the financial conflicts of interest they have." Even if they are, Relman asserts, the patient—who is often sick, intimidated, and frightened—is put in the unfair position of worrying if the doctor's motives are in their best interest.

Relman believes that the state should and will pass a law prohibiting physicians from referring patients to any health-care facility in which they have an economic interest. Congress passed such as law in 1978 with regard to Medicare and Medicaid patients. The legislation that Relman proposes is controversial, however. "Such a law would be prejudicious and discriminatory, and would not serve the Commonwealth," says Blackburn. "In my case," he adds, "it would deny my patients the best care." Flier also would strongly oppose such legislation, and believes it would do more harm than good. "In many cases,

the things that physicians have an economic interest in may be better than the alternatives." Flier's rationale is that people are motivated to invest time and money in efforts they believe are good.

Others, such as Leon Eisenberg, find no fault with the intent of Relman's suggested law, but believe that the many potential gray areas would make it difficult to write and to enforce. At the very least, both Relman and Eisenberg advocate an ethical code for physicians that would strongly discourage combining entrepreneurialism with patient care. "An ethical code," Relman acknowledges, "is not going to make doctors more ethical . . . but it is going to remind them of what they are supposed to do."

Concerns about entrepreneuralism in medicine do not stop with the ethical issues, however. Many physicians—including some entrepreneurs—fear the repercussions of medicine being viewed as a business. "If doctors insist on having business interests in facilities, and services to which they refer patients, or which they can influence in some way, they are ultimately going to be treated and viewed by the public and by government as businessmen," Relman says. The results, he adds, is that they will progressively lose their professional autonomy and will "be regulated, controlled, and legislated just the way businessmen are."

Eisenberg, although also concerned, is more optimistic about the role that government can and does play in regulating medical practice. "Doctor's shouldn't be free to do the wrong thing," he says. "There have always been, and there should be, controls on defining at least the minimum of good practice." What he hopes government will avoid is regulation that would take away the doctor's leeway to adjust for differences between patients when making clinical decisions.

Blackburn agrees that a loss of professional autonomy would be "a disaster," but he doesn't think entrepreneurialism will have that kind of effect in medicine. The public values health care too highly to let the current code of medical ethics be replaced by laws, and the legislature, says Blackburn, is "not going to get involved in making a business out of medicine." Overall, he thinks that marketplace forces in medicine have a generally positive impact, resulting in a more systematic approach to patient care.

An ongoing trend ● "Medicine is moving into the commodity arena," says Harold Solomon, who sees no way of stopping the trend. "We are 'mediocritizing' American medicine," he says, but it is not "a sinister or unique phenomenon." Instead, he finds that the process is happening everywhere in business and industry. "These are exciting time in medicine," Solomon says, "and no one can predict the outcome."

Both Relman and Eisenberg concede that entrepreneurialism has had some positive effects. Says Relman, it has "stirred the pot," bringing new products and new services onto the market more quickly than might have happened without a profit motive. "It was physicians who started outpatient renal dialysis," Eisenberg comments, and now it is available at a much lower cost to the community.

"There are those who will criticize people like me and people like Blackburn . . . no matter how well we practice medicine," says Greenwald. "But as long as the patient is getting super care, the rest is just the way of the world, and there is nothing we can do about it. If you are not going to be part of the growing trend in medicine, you certainly can't stop it."

Lisa Underhill
Freelance Science Writer
Brookline, Massachusetts

Reprinted with permission from *Massachusetts Medicine*, Massachusetts Medical Society, May/June 1987, pgs. 40-43.

Fighting quackery
A quick-reference guide

Quackery—defined as anything associated with false claims in the field of health—costs Americans at least $10 billion a year. The majority of citizens have been victimized in some way without realizing it.

Do consumers of "natural" foods question their higher price? Do people who take vitamin pills for health "insurance" try to determine whether they really need them? Do those who keep trying new brands of pain reliever realize how many of them have identical ingredients? Do victims of tooth decay who live in communities without flouridated water know how flouridation could have helped them? Not usually. These forms of quackery don't kill anyone, but their existence in our society reflects widespread and powerful forces working against the public interest.

Thousands of books promote questionable health ideas, particularly in the area of nutrition. Talk shows abound with guests who deliver false information. Ads for health products sold by mail are almost always misleading. The most serious forms of quackery do kill victims by persuading them to abandon effective medical treatment.

Quackery is also dangerous to medical practice and to science itself. To enhance their own credibility, many promoters of quackery criticize physicians unfairly, attack orthodox treatment, and suggest that testimonial evidence is more reliable than the results of controlled experiments.

Most victims of quackery are not gullible but merely unsuspecting. People tend to believe what they hear most often. They also tend to believe that government is working effectively to protect its citizens from

false advertising and other misleading claims in health matters. Many types of quackery are promoted by persons who sincerely believe in what they are doing—which makes them even more persuasive.

What can be done?

The first step in fighting quackery should be to examine your own feelings to make sure they contain no hidden resistance. Are you afraid that you don't have time for effective action? Or that your patients won't listen? Or that you don't know enough about suspicious promotions to take a stand? Or that you might be sued for speaking out? Fears of this type are rarely warranted.

Antiquackery strategies that are not time-consuming can easily be incorporated into everyday medical practice. Most patients *will* listen to their physician. Information is easily obtained if you know where to look (see list at end of this article), and lawsuits can be avoided by following a few simple principles. Here are some practical tips.

- Make sure that patients with psychophysiologic symptoms understand the physiologic basis of their symptoms. Never tell someone who has symptoms "there's nothing wrong with you" or "it's all in your head." Some physicians think that such phrases are reassuring, but patients interpret this type of remark to mean that the physician believes they are imagining their symptoms or malingering. Patients' symptoms are quite real to them, and persons who feel misunderstood are very vulnerable to quackery.
- Minimize use of placebos. If symptoms are related to stress, take the time to find out what is troubling the patient or refer him or her to someone who will.
- Keep in mind that patients with a chronic illness, such as arthritis, multiple sclerosis, or cancer, are particularly vulnerable to quackery. Help you patients make the best of their situation, and warn them to resist quack sales pitches that offer false hopes.
- Take a vitamin history. Most people who take vitamins don't need them. Consuming excess vitamins is never harmless: This practice indicates that misinformation about nutrition has been absorbed by the patient, which means that the patient is likely to be vulnerable to more serious misinformation. After your relationship with the patient is solidly established, find out why he or she is taking vitamins and give appropriate advice. Criticism given too soon to a "true believer" may drive the patient to another doctor.
- Complain when your local media promote quackery. If you notice a newspaper article or radio or television broadcast or ad that contains health misinformation, complain to the source. Many doctors fear that this type of criticism will get them embroiled in a libel suit. There is no risk of lawsuit as long as you avoid name-calling and stick to the facts. Just indicate why you disagree with the statements in question. If you wish to avoid public involvement, an off-the-record telephone call to the writer, newspaper editor, or station manager can also be effective.
- If you see a misleading newspaper or magazine ad, send a copy to your congressional representative with a request that it be forwarded to the appropriate federal agency for investigation. Complaints received from lawmakers are likely to receive more attention than those sent directly to the agency.
- Encourage victims of quackery to file a lawsuit. This takes little time and is the most effective way of putting some quacks out of business. Victims are most likely to follow through if they are referred to an attorney who is interested in such cases and will take meritorious ones on a contingency fee.

Sources of Information on Quackery

BOOKS

The Health Robbers Ed 2. Barrett S., ed. 1980, George F. Stickley Co. 210 W. Washington Square, Philadelphia, PA 19106. $14. A comprehensive analysis of quackery.

Vitamins and "Health" Foods: The Great American Hustle Herbert V., Barrett S. 1981, George F. Stickley Co. 210 W. Washington Square, Philadelphia, PA 19106. $9. Analysis of nutrition quackery and its major promoters.

PERIODICALS

Nutrition Forum Barrett S., ed. George F. Stickley Co. 210 W. Washington Square, Philadelphia, PA 19106. $30 yr for 12 issues. Nutrition news with an emphasis on quackery.

FDA Consumer Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. $9.50/year for 12 issues. Excellent discussions of nutrition, food safety, drugs, medical devices, and government enforcement action.

ORGANIZATIONS

The National Council Against Health Fraud Inc. P.O. Box 1276, Loma Linda, CA 92354. Professional membership, $25/year. Has 2,100 members and chapters in 13 states; publishes a bimonthly newsletter issues position papers, and maintains an information clearinghouse (Phone: 714 796-3067); welcomes inquiries from the media.

The Lehigh Valley Committee Against Health Fraud Inc. P.O. Box 1747, Allentown, PA 18105. Answers questions by mail or telephone (215 437-1795); welcomes inquiries from the media.

Stephen Barrett, M.D.
Allentown, Pennsylvania

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Primary care—does it have a future?

Primary care is very much in the limelight these days. It is actively espoused by the family practice movement, and general internal medicine, pediatrics and obstetrics/gynecology are placing increasing emphasis on what is now being called primary care. The federal government has begun to shift some of its emphasis and support from training specialists and subspecialists to training for primary care. Primary care is seen as the entry point where a patient has first contact with the health care system and from whence he or she is referred to whatever specialists or subspecialists may be needed. It is also viewed as a place where ongoing care is easily coordinated and continuity of care can be achieved. Moreover, it is not lost on the payors for care that a primary care physician is in a strong position to decide upon the kind and amount of care that is given, and therefore what it will cost. Thus there is a growing effort to place a primary care physician in the position of "gatekeeper" with an incentive and responsibility to consider costs when deciding what should be done for a patient.

One at first might think that primary care and primary care physicians are something new, but they are not. Primary care has been there all the time and physicians have rendered it to their patients. But for many years the focus in medical education and medical practice has been on the training of specialists and subspecialists, and medical practice became, almost de facto, divided into specialties and subspecialties. Patients, physicians and patient care all tended to become compartmentalized. But in recent years there have been countervailing forces. Perhaps most important is a growing student interest in the broader and more human aspects of patient care that began more than a decade ago. Then there was coming to be a surfeit, if not a glut, of physicians with far too many specialists, and a perception that there were far too few generalists or primary care physicians. Too many patients were shopping around for their own specialists; many were seeing several specialists at once and, for better or worse, in effect prescribing their own treatment. Another important countervailing force has been the modern development of primary care and the role of the primary care physician. This has been notably assisted by a government that has been reducing its support of specialty and subspecialty training while increasing its support for the training of health professionals for primary care.

Besides being the entry point, and now being looked upon by some as the gatekeeper for patient care, the primary care movement has shown a special interest, not only in the more common ailments to which the flesh is heir, but also in the effect of illness upon a patient and the family, the effect of illness upon the interaction of a patient with his or her environment and the role of the family and others in helping to overcome the illness and its effects. Again, this is not new, but the emphasis on it has been much greater than has been the case in the training and practice of many specialists and subspecialists. But is this enough, or is there more that primary care could be interested in? Is it enough to assure that primary care does indeed have a future as a discipline in medical education and patient care?

One senses that a genuine discipline is needed. But what might it be? Most of the science and technology in patient care is subsumed under one or another of the specialties or subspecialties. Research into health care delivery is being explored in terms of primary care, but somehow seems to miss the main focus of interest. Yet research, and good research, is needed to support an academic discipline and to secure it a respected position among scientific and technologic specialty peers in patient care. This will be essential if primary care, as it is coming to be known, is to have the future it could have, and probably deserves.

Primary care is above all an interaction between a doctor and a patient, and continuing care has to be a continuation of this interaction. To be sure, this interaction occurs between doctor and patient in all specialties, but too often in these specialties it may have second place to technological intervention. In primary care, however, the opposite may more likely be the case, and the human interaction may play the more important role with the technological interventions more subservient. There has been little scientific or quantitative study of this all-important topic. There is need objectively to address the phenomenon of the doctor-patient relationship, the skills that can be developed and used within it, the components of what has been called the art of medicine, and the need to relate these to patient and physician satisfaction, and to health care outcomes, particularly in primary care, where so much of the emphasis is on human interaction.

The pendulum seems to be swinging. There is a growing sense that modern medical science and its technology are not everything in patient care. While primary care is nothing new, a renewed emphasis on it, and what it is trying to do, could be the beginning of a new understanding of the phenomena involved in that very special interaction between doctor and patient that is, after all, the most essential ingredient in patient care.

Malcom S. M. Watts, M.D.
San Francisco

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It isn't always easy

On many occasions, children—our own, those from the neighborhood or those from the local school—want to learn about our lives as physicians. I am biased. I tell them that I believe there isn't a greater satisfaction in life than providing relief and comfort to another person when he is distressed. I explain that there isn't a better reward for our efforts than when a person comes to understand his illness and learns to live with whatever limitations he may have. I also inform the inquiring youngster of the many physicians who speak proudly of the patients who continue to return for their assistance and advice for many years, some even for a lifetime. And many physicians proudly state that members of several generations of the same family are among their patients.

But, being a physician isn't always easy. There will not always be happy endings. The knowledge of a poor prognosis, sometimes many months before an unhappy conclusion, often pains physicians. The realization that a serious complication might have been prevented if the patient had sought help earlier is even more difficult to accept Frustration aggravates this pain because physicians realize that such patients had advice available, but chose not to seek or follow it, discontinued treatment too early, or did not return for follow-up care.

As physicians, we feel for our patients: for the young woman who is now infertile because she did not complete her treatment for salpingitis; for another who didn't follow our advice to prevent the birth of a premature infant; for the patient we advised and offered alternatives to smoking who now develops an oral, pharyngeal or lung cancer; and for those patients with complications from alcohol and drug abuse and from their dangerous, reckless lifestyles. The human feelings evoked, however, do not prevent physicians from treating these patients. We have been trained to be objective and non-judgmental. We treat convicted criminals. We learn to tolerate offensive odors and inappropriate personal appearances. We often risk contagion and other forms of personal harm. But, society also holds physicians to stricter, higher standards in many areas. Sometimes we are expected to perform tasks which are not humanly possible. For instance, society expects physicians, both individually and collectively, to resolve the problem of the care of the uninsured, homeless, hungry, abused, or even the high cost of medical care. Physicians are blamed when these serious problems continue unabated. Even though we are doing our best, we often do not receive fair treatment or adequate respect.

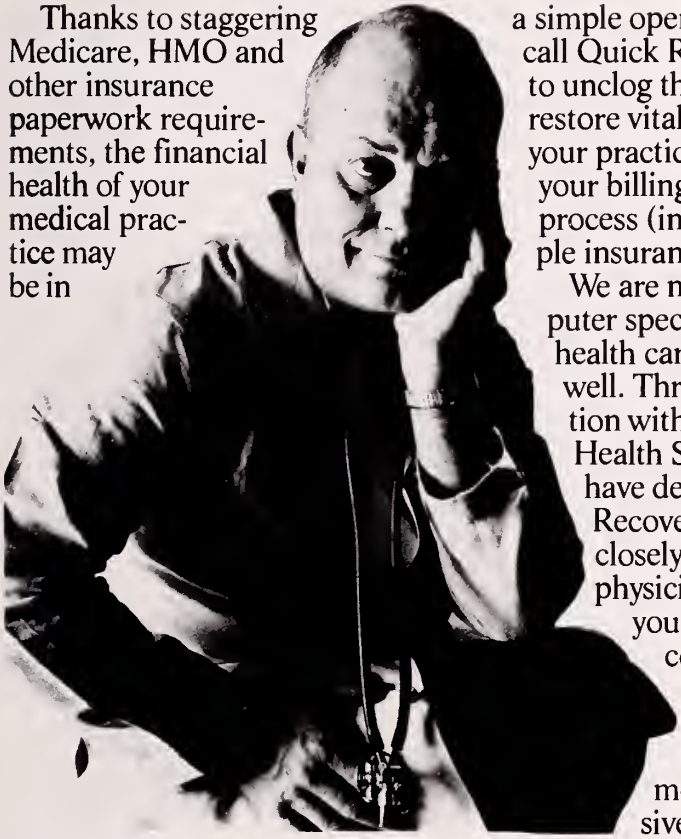
Despite these disappointments, we will continue to do our best to keep alive the dream that originally took us to medical school. But I am biased. I know that in many occupations and specialties there are many reasons for satisfaction. Some of them may be easier. But even though it may interrupt a meeting or my nocturnal circadian rhythm, there isn't anything better for me than the lusty scream of a pink newborn who is surrounded by a watery-eyed mother and a proud father. I am proud to be a physician, and if any of my children, or grandchildren, decide to become a physician, I will help them; I will be thrilled, happy and proud of their choice of vocation.

Although it isn't easy, there isn't anything better than being a physician.

Pedro A. Poma, M.D.

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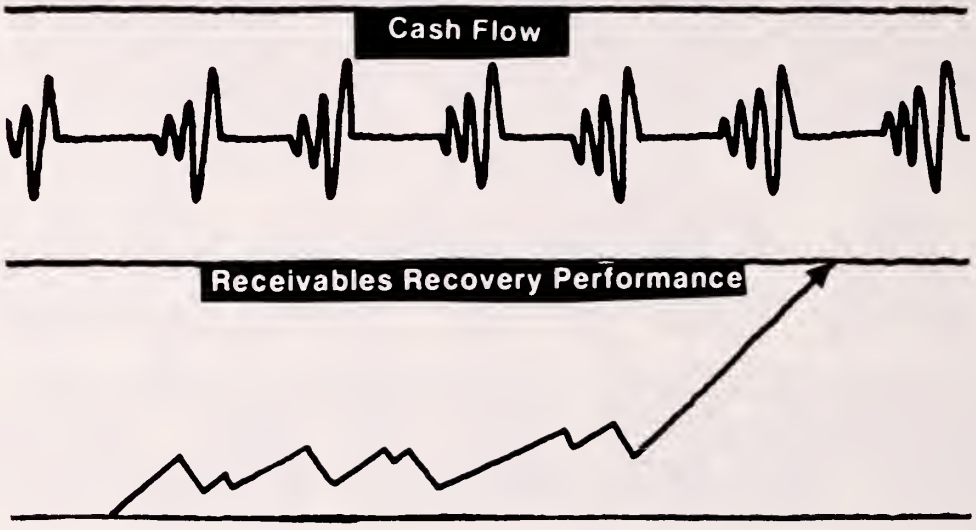
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Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Auxilians attend Legislative Sessions in Tallahassee

All aboard! This was the call sounded throughout the state as Auxilians gathered on trains, planes, buses, and automobiles for the annual trek to Tallahassee for "Days at the Capital" May 11-13, 1987.

This year's event was a joint effort by the Florida Medical Association and the Auxiliary. Nancy Corwin, Auxiliary Legislative Chairman, planned an outstanding program in conjunction with the Association and its staff. Legislative issues affecting the practice of medicine loomed high on the priority listing of current concerns.

Foremost on the minds of the members were the challenges posed to all who are concerned with quality health care for everyone. The scheduled agenda was geared to helping physicians and their spouses to implement and achieve this goal.

Pinellas County Auxilians were among the many Auxilians present for "Days at the Capital." Leading the Pinellas delegation was FMA Auxiliary President-Elect, Betty Orr. Other members included: County President, Syd Entel; County President-Elect, Mary Mallette; South Branch Chairman, Davene Seeger; North Branch Chairman, Sally Laufer; and County Legislative Chairman, Linda Lerner.

Pinellas County Medical Society supported the efforts of its Auxilians by chartering a bus to take them to "Days at the Capital." The time on the bus was used to bring the Auxilians up-to-date on current issues being debated in the Legislature.

Upon arrival in Tallahassee, first-time attendees met for a "newcomers orientation." A general session followed with a presentation by George S. Palmer Jr., FMA Director of Legislative Affairs, and John Kasper, AMA Field Representative. Aide to Representative Bill Bankhead, Laura Rowell, alerted participants to "Who's Who, What, When and Where at the Capitol?" E. Charlton Prather, M.D., Acting Deputy Assistant Secretary for Health, and State Health Officer, Pete Breslin, Deputy Assistant Secretary for Boards and Commissions, Department of Professional Regulation, and Jack Maynard, Director of Public Information, DPR, discussed the relationships of these agencies to medicine.

On the second day, participants coverged on the House and the Senate to observe the proceedings. The Pinellas group, as well as the other attendees, arranged to meet individually with their legislators and their aides on a one-to-one basis. They also visited Capital offices making their presence known and felt in Tallahassee. The Pinellas Auxilians attended the House Session where they watched the passing of the "Indigent Care Bill." They had the privilege of being recognized as a group by their Representative, Peter Rudy Wallace.

The next stop was the Senate. Here they were present for the debate and final passage of the "Cleveland Clinic Bill."

Not only were "Days at the Capital" moments of Auxiliary and Association comaraderie, but also times of political acumen. It was an important step toward a greater understanding of the political process. Planning and preparation were vital tools in helping to make these days successful. As one Auxilian remarked, "I came away from Tallahassee with a determination to become more active, and thus more effective, in politics and legislation." Yes, by working together we can influence the passage of legislation favorable to medicine and quality health care for everyone.

Mrs. William (Mary) Mallette
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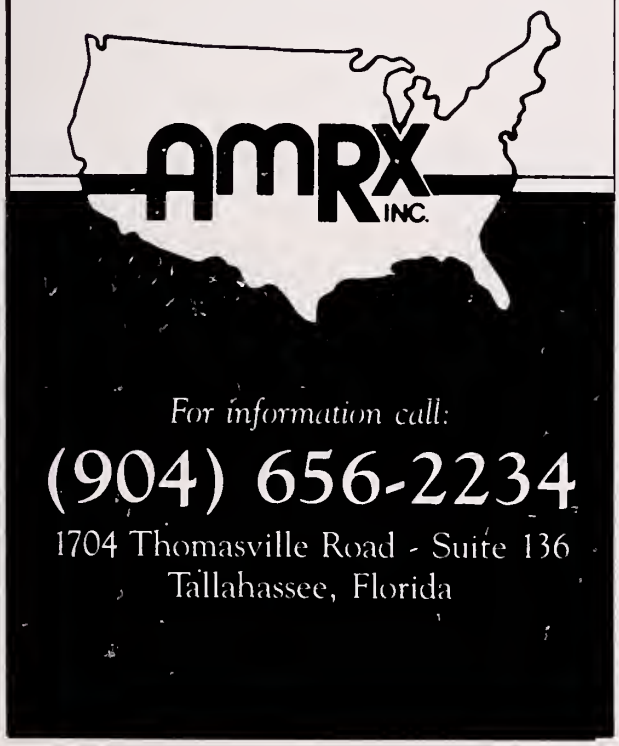
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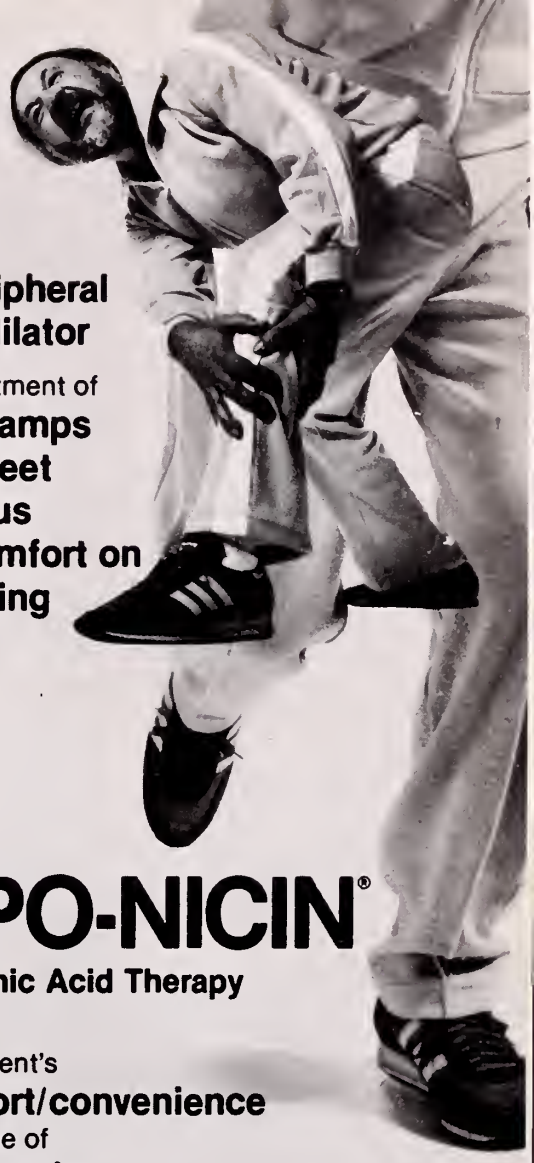
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Primary Care & Preventive Medicine, July 8-11, Peabody Hotel, Orlando. Contact: Drs. A. Varraux & J. Herran, (305) 841-5144.

1987 Clinical Conference on Pre-Hospital Emergency Care, July 9-12, Orlando Hyatt, Kissimmee. Contact: Registrar, (305) 628-4800.

AUGUST

Fourteenth Annual Review Course for Certification in Internal Medicine, "Fundamental and Clinical Aspects of Internal Medicine," August 2-15, Key Biscayne Hotel and Villas, Key Biscayne. Contact: Jose S. Bocles, M.D., (305) 547-6063.

Coronary Heart Disease: Current Concepts, August 14-15, Orlando Hyatt Hotel, Orlando. Contact: Karen DeBent, (800) 421-3756.

American Heart Association ACLS Instructor Course, August 29-30, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

SEPTEMBER

Annual Pediatric Symposium — 1987, Sacred Heart Hospital, Pensacola. Contact: Barabara J. James, (904) 477-4956.

Doppler Echocardiography Seminar, September 10-12, Innisbrook Resort Conference Center, Tarpon Springs. Contact: Registrar, Ultrasound Center, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, N.C. 27103 or call (919) 748-4505.

Magnetic Resonance Imaging: A Technologist's New World, September 10-12, Peabody Hotel, Orlando. Contact: Martin Silbigu, M.D., (813) 974-2538.

Medical Malpractice, Prevention & Defenses, September 16-16, Miami Beach. Contact: Mt. Sinai Medical Center, Attn: CME Coordinator, 4300 LAton Rd., Miami Beach, FL 33140. (305) 674-2311.

Head & Spinal Cord Injury, September 17-18, Pensacola. Contact: Phyllis Connerley, (904) 478-4460 ext. 4178.

Pediatrics for the Practitioner, September 18, Sheraton Tampa East, Tampa. Contact: H. Pomerance, M.D., (813) 974-4214.

Current Concepts in the Diagnosis and Management of Adult Heart Disease, September 18-19, New World Landing, Pensacola. Contact: (904) 478-4460.

OCTOBER

The Friary's Sixth Annual Professional & Chemical Dependency Seminar, October 2, Pensacola Beach. Contact: Brunie Emmanuel, (904) 932-9375.

Emerging Trends in Critical Care—1987, October 7-9, Crowne Plaza Hotel, Orlando. Contact: Rick Mace, (305) 897-1575.

Cardiopulmonary Update, October 9-11, Marriott at Sawgrass, Ponte Vedra Beach. Contact: Alberta Hipps, 1800 Barrs St., Jacksonville 32203. (904) 387-7563.

International Symposium on Gynecologic Oncology, Surgery and Urology, October 18-23, Japan. Contact: Patti Mundy, (305) 549-6944.

Thirteenth Annual Panamerican Seminar, October 19-23, Mt. Sinai Medical Center, Miami Beach. Contact: Mt. Sinai Medical Center, Attn: CME Coordinator, 4300 Alton Road, Miami Beach 33140. (305) 674-2311.

Magnetic Resonance Imaging, October 19-23, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Fall 1987 Familly Practice Review, October 19-23, Peabody Hotel, Orlando. Contact: Grace Wagner, JHMHC J-233, Gainesville 32610. (904) 392-4321.

A Case Study Approack to Risk Management and Malpractice, October 23, Sheraton, Bal Harbour. Contact: Gloria Allington, University of Miai, P.O. Box 016960, Miami 33101. (305) 547-6716.

Thirteenth Annual Gulf Coast Internal Medicine Conference, October 23-24, Pensacola Hilton, Pensacola. Contact: Dr. Garth Grove at (904) 474-7101.

Twenty-eighth Workshop in Electrocardiography, October 28-31, Sheraton Sand Key, Clearwater Beach. Contact: Henry Marriott, M.D., (813) 894-0790.

Fifth Annual Advanced Neuroradiology, October 29-31, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, (813) 974-2538.

A Case Study Approach to Risk Management and Malpractice, October 31, Contemporary Hotel in Walt Disney World. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

NOVEMBER

Primary Care Update: Seventy-second Scientific Assembly, November 2-5, Diplomat Hotel, Hollywood. Contact: Ray W. Giffor Jr., M.D., (608) 257-6781.

Thirteenth Annual Obstetrics and Gynecology Review Course, November 3-11, Doral Hotel on the Ocean, Miami. Contact: Patti Mundy, Dept. of OB/GYN, University of Miami, P.O. Box 016960, R-116, Miami 33101. (305) 549-6944.

Advanced Applied Ultrasound in Obstetrics, November 5-7, Bowman Gray School of Medicine, Naples. Contact: Regsitrar, Ultrasound Center, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, N.C. 27103 or call: (919) 748-4504.

American Heart Association ACLS Instructor Course, November 7-8, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D., (813) 251-6911.

Thirteenth Annual OB/GYN Pathology Course, November 12-15, Doral Hotel on the Ocean, Miami Beach. Contact: Patti Mundy, Department of OB/GYN, University of Miami, P.O. Box 016960, R-116, Miami 33101.

Thirteenth Annual OB/GYN Pathology Course, November 12-15, Doral Hotel on the Ocean, Miami Beach. Contact: Patti Mundy, Dept. of OB/GYN, University of Miami, P.O. Box 016960, R-116, Miami 33101.

The Distal Radioulnar Joint, November 13-14, Orlando. Contact: Paula Scheid, 3025 S. Parker Rd., Suite 65, Aurora, CO 80014. (303) 755-4588.

Flexible Sigmoidoscopy, November 14-15, Sonesta Beach Hotel, Key Biscayne. Contact: John P. Christie, M.D., (305) 687-1367.

All America's Health '87, November 15-18, Curtis Hixon Convention Center, Tampa. Contact: Pierre J. Bouis Jr., M.D., (813) 974-4296.

DECEMBER

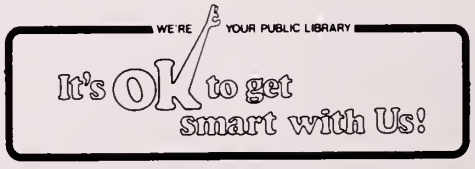
Clinical Allergy & Immunology for the Practicing Physician, December 3-5, Buena Vista Palace, Lake Buena Vista. Contact: Richard F. Lockey, M.D., (813) 972-7631.

1987 Neuro-Opthalmology Course, December 3-5, Key Biscayne Hotel, Key Biscayne. Contact: Goby Kressly (305) 326-6031.

Diagnosis & Management of Respiratory Diseases, December 4-6, Boca Raton Hotal, Boca Raton. Contact: Karen DeBont, (800) 421-3756.

1987 FINA World Medical Congress, December 5-8, Justus Aquatic Center/Radisson Hotel, Orlando. Contact: Allen Richardson, M.D., (303) 578-4575.

A Case Study Approach to Risk Management and Malpractice, December 18-19, Sheraton, Bal Harbour. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

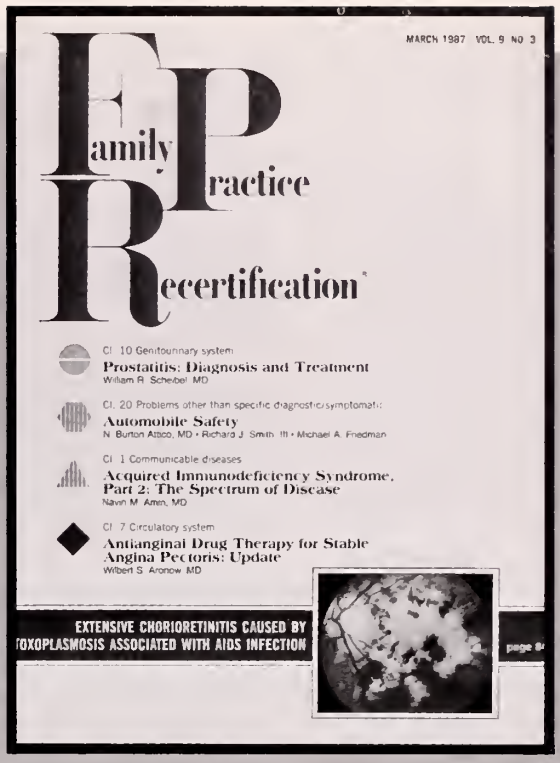


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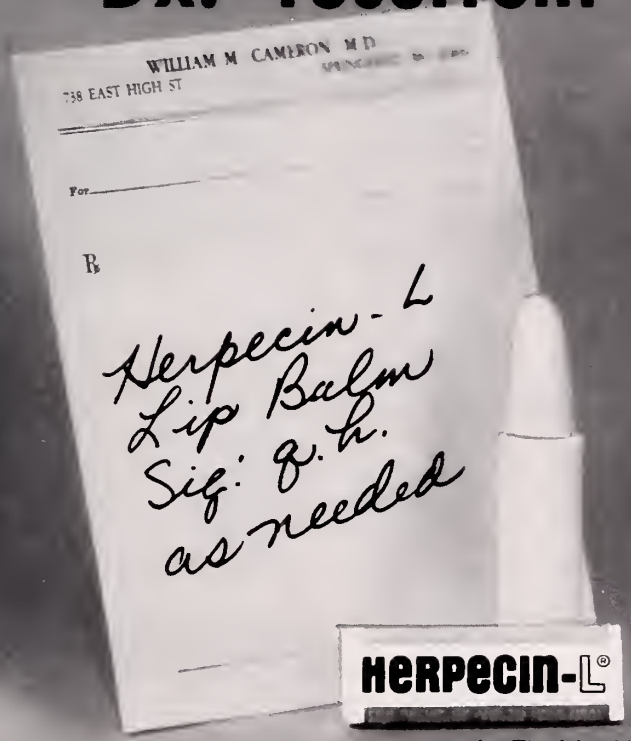
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ORTHOPAEDIST: Univeristy trained, board eligible or board certified, American citizen, under age 40. Location: East coast of central Florida. Practice: General orthopaedics. Write: Box C-1389, P.O. Box 2411, Jacksonville, FL 32203.

CARDIOLOGIST: BE/BC, excellent opportunity with outstanding potential. Modern progressive hospital in an ideal southern family community. Write: Box C-1393, P.O. Box 2411, Jacksonville, FL 32203.

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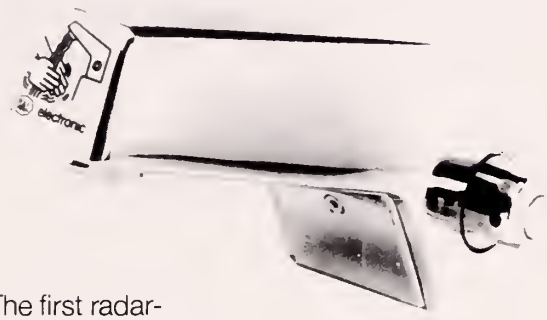
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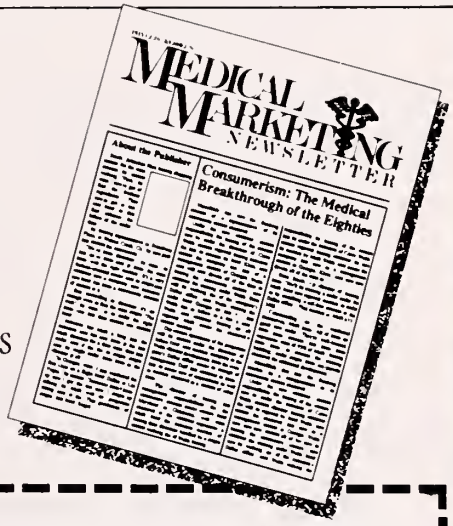
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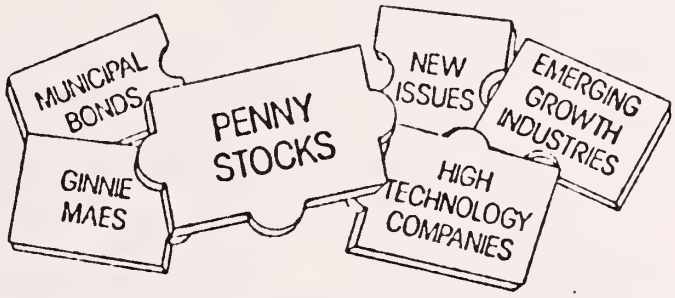
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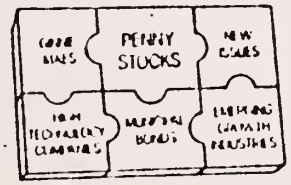
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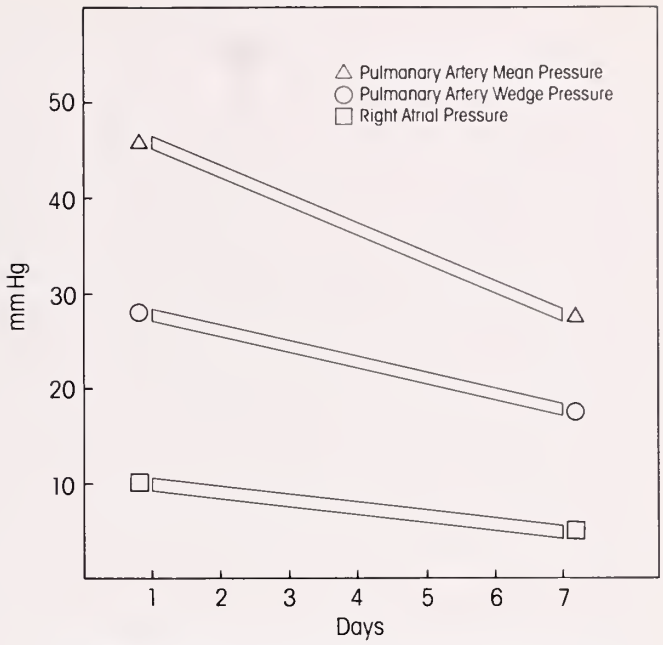
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Ten patients with CHF showed marked hemodynamic improvement after seven days of BUMEX® (bumetanide/Roche) (mean values ± SE). Adapted from Olesen, *et al* [1]

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Before prescribing, please consult complete product information, a summary of which follows:

WARNING: Bumex (bumetanide/Roche) is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dosage schedule have to be adjusted to the individual patient's needs. (See under DOSAGE AND ADMINISTRATION in complete product information.)

INDICATIONS AND USAGE: Edema associated with congestive heart failure, hepatic and renal disease, including the nephrotic syndrome
Almost equal diuretic response occurs after oral and parenteral administration of Bumex. If impaired gastrointestinal absorption is suspected or oral administration is not practical, Bumex should be given by the intramuscular or intravenous route
Successful treatment with Bumex following instances of allergic reactions to furosemide suggests a lack of cross-sensitivity.
CONTRAINDICATIONS: Anuria. Hypersensitivity and in patients in hepatic coma or in states of severe electrolyte depletion. Although Bumex can be used to induce diuresis in renal insufficiency, any marked increase in blood urea nitrogen or creatinine, or the development of oliguria during therapy of patients with progressive renal disease, is an indication for discontinuation of treatment
WARNINGS: Dose should be adjusted to patient's needs. Excessive doses or too frequent administration can lead to profound water loss, electrolyte depletion, dehydration, reduction in blood volume and circulatory collapse with the possibility of vascular thrombosis and embolism, particularly in elderly patients.
Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risks to the patients
In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients.
In cats, dogs and guinea pigs, Bumex has been shown to produce ototoxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ototoxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially at high doses.
Patients allergic to sulfonamides may show hypersensitivity to Bumex
PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets. Hyperuricemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion.
Possibility of effect on glucose metabolism exists. Periodic determinations of blood sugar should be done, particularly in patients with diabetes or suspected latent diabetes
Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions
Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions
Drugs with nephrotoxic potential and bumetanide should not be administered simultaneously
Since lithium reduces renal clearance and adds a high risk of lithium toxicity, it should not be given with diuretics.
Probenecid should not be administered concurrently with Bumex
Concurrent therapy with indomethacin not recommended
Bumex may potentiate the effects of antihypertensive drugs, necessitating reduction in dosage
Interaction studies in humans have shown no effect on digoxin blood levels
Interaction studies in humans have shown Bumex to have no effect on warfarin metabolism or on plasma prothrombin activity
Pregnancy: Bumex should be given to a pregnant woman only if the potential benefit justifies the potential risk to the fetus
Bumetanide may be excreted in breast milk
Pediatric Use: Safety and effectiveness below age 18 not established
ADVERSE REACTIONS: Muscle cramps, dizziness, hypotension, headache and nausea, and encephalopathy (in patients with preexisting liver disease).
Less frequent clinical adverse reactions are weakness, impaired hearing, rash, pruritus, hives, electrocardiogram changes, abdominal pain, arthritic pain, musculoskeletal pain and vomiting
Other clinical adverse reactions are vertigo, chest pain, ear discomfort, fatigue, dehydration, sweating, hyperventilation, dry mouth, upset stomach, renal failure, asterixis, itching, nipple tenderness, diarrhea, premature ejaculation and difficulty maintaining an erection.
Laboratory abnormalities reported are hyperuricemia, azotemia, hyperglycemia, increased serum creatinine, hypochloremia, hypokalemia, hyponatremia, and variations in CO_2 content, bicarbonate, phosphorus and calcium. Although manifestations of the pharmacologic action of Bumex, these conditions may become more pronounced by intensive therapy
Diuresis induced by Bumex may also rarely be accompanied by changes in LDH, total serum bilirubin, serum proteins, SGOT, SGPT, alkaline phosphatase, cholesterol, creatinine clearance, deviations in hemoglobin, prothrombin time, hematocrit, platelet counts and differential counts
Increases in urinary glucose and urinary protein have also been seen.
DOSAGE AND ADMINISTRATION:
Oral Administration. The usual total daily dosage is 0.5 to 2.0 mg and in most patients is given as a single dose
Parenteral Administration: Administer to patients (IV or IM) with GI absorption problem or who cannot take oral. The usual initial dose is 0.5 to 1 mg given over 1 to 2 minutes. If insufficient response, a second or third dose may be given at 2 to 3 hour intervals up to a maximum of 10 mg a day.
HOW SUPPLIED: *Tablets,* 0.5 mg (light green), 1 mg (yellow) and 2 mg (peach), bottles of 100 and 500, Prescription Paks of 30; Tel-E-Dose® cartons of 100. Imprint on tablets: 0.5 mg—ROCHE BUMEX 0.5, 1 mg—ROCHE BUMEX 1, 2 mg—ROCHE BUMEX 2
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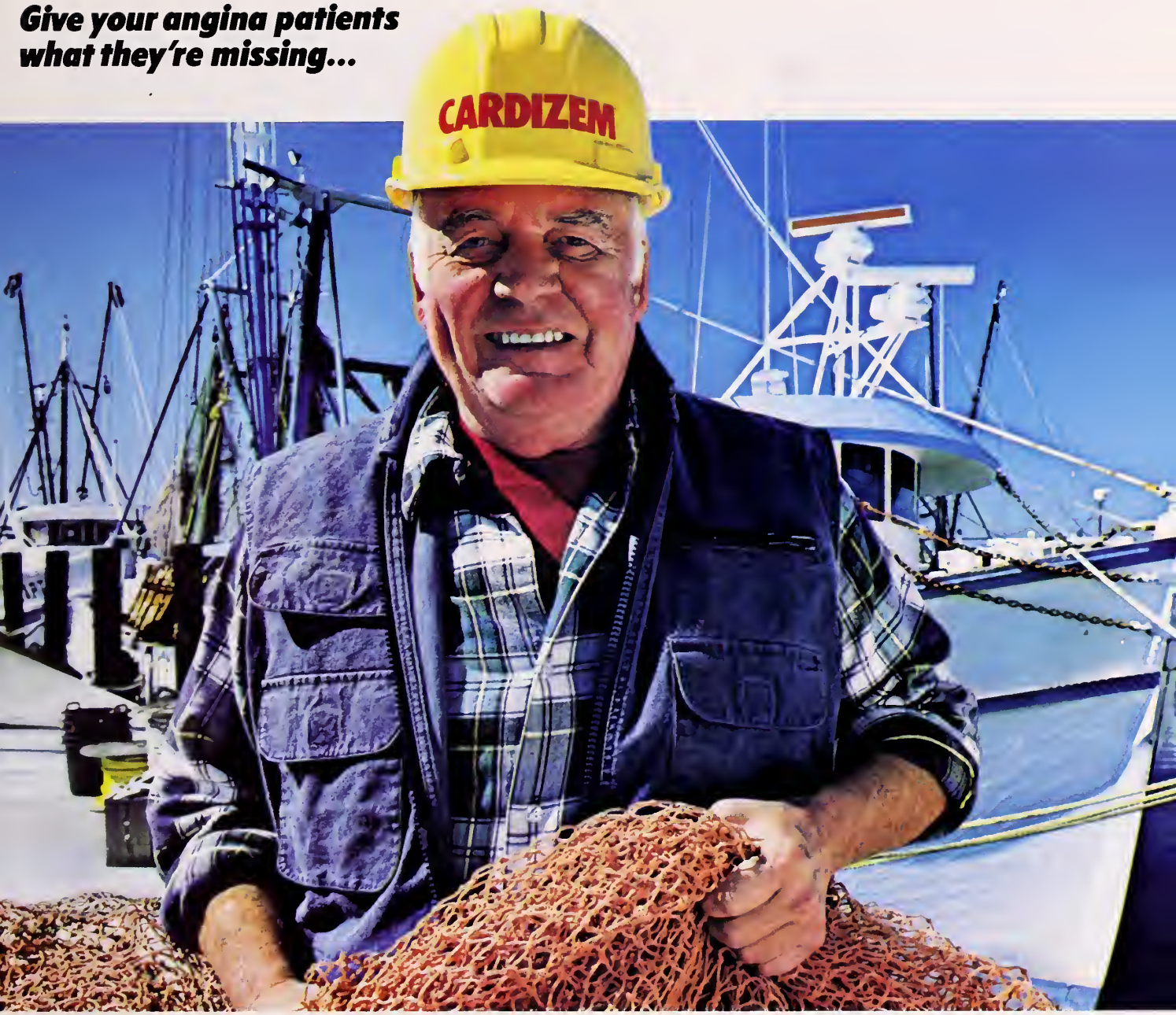
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60 mg tid or qid

Brief Summary
Professional Use Information

CARDIZEM®
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CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%).

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

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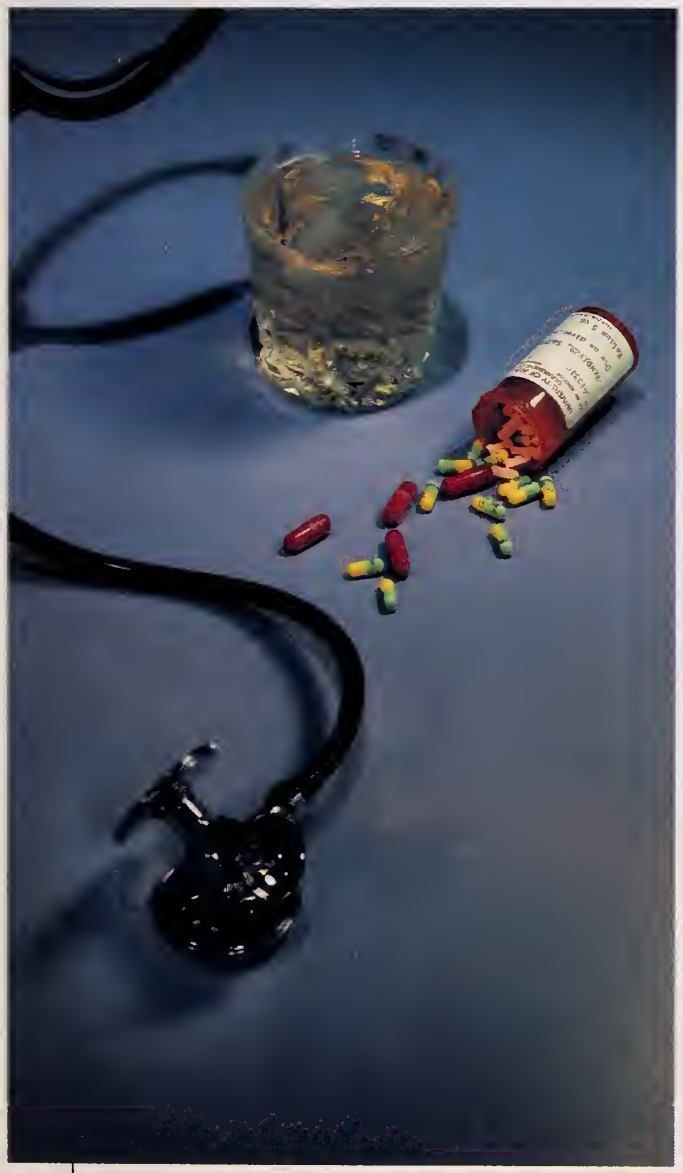
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JULY 1987, Vol. 74, No. 7

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This month's cover of *The Journal* is a photograph by FMA Director of Medical Economics, Robert W. Seligson, M.B.A., depicting the spirit of Independence Day.

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A day of reflection



Every physician in the state is now approaching a time for serious soul searching. I'm sure that in 1776 this was the case for most Americans — those who were physicians, as well as every member of society. It is of interest that at the time our founding fathers worked on the Constitution the anger and frustration that led to the War for Independence had somewhat abated. As we celebrate the history of that famous document it is only appropriate that we realize that at the time of the writing, cool heads prevailed and a model that was to last throughout our lifetime and perhaps several hundred if not thousands of more years was carefully thought out with complex solutions to the many vested interests that existed in the original 13 states.

So, too, in our crisis here in Florida the common knowledge is that there is a problem with the "tort abuse syndrome" which cannot be negated. We know that frustration, anger and hatred toward those who have perpetrated the amorality of society to lead our country and state into such a mess cannot be alleviated with the stroke of a pen or venting spleen in a publication either printed or electronic, without due process, and thorough consideration of all tangents and factors. So we must now put all the emotion aside in our deliberations with those through whom we hoped to accomplish progress.

Several parallel courses are underway. The legislative process will function in Tallahassee and sooner or later the working Ad Hoc Committee of the Academic Task Force and that group itself will have a solution garnered from their deliberations. In the meantime the Governor's work group will meet and try and come up with a vehicle. This will undoubtedly have considerable input from the committee staffs of the House as well as the Senate Commerce Committee structure and the Florida Medical Association staff. Hopefully we will have some input with these people who are allies and comrades in the legislative process. Concomitantly the Florida Medical Association work group will be involved and individuals undoubtedly will be a part of this functioning and writing committee. Hopefully, clear heads will prevail and a consensus will be formulated that takes all aspects of the complex issue into consideration and with an eventual "Solution" which will be honed into a bill. Some of it will be realistic, some will shift cost and some will be punitive for all parties concerned. How does this affect us in the here and now?

Many physicians can neither afford insurance nor are they able to practice without it. Others ignore the whole process and have been practicing without it for a number of years and will continue to do so. Altruistic reasons one way or another are not necessarily involved in these decisions. Oaths and Good Samaritans notwithstanding, medicine is still a small business with payrolls, bills and other insurance, and rents or mortgages to be paid. This is about 30-40% of the gross income of most physicians. Liability insurance now has reached approximately 12% of the gross income of physicians over the entire state and in some specialties amounts up to 30% and even higher. Capitation, limited return on investment of time, and the ratcheting down of income by third party intermediaries make "this business" hardly worth the time, effort, and stress it takes to run it.

In the same vein, people, because of hundreds of reasons, love to sue and get what they can out of the system. They feel that they have their just "rights." The same group sues police, their religious institutions, the power company, and their neighbor. This is unfortunate, since most of them bite the hand that feeds them and fail to see that sooner or later they will end up paying the piper for their ill gotten and/or possibly even justified gains. It seems that it is time for people to wake up to their responsibility to themselves and to society in general. Mayhem and continuation of amorality are undoing the concept and fabric of our nation and our reliance on the Almighty Creator has become secondary or even totally abrogated.

Hopefully we all can realize this before it is too late! It cannot be legislated. Actions speak louder than words and from the attitude of many citizens in this country these actions are less than admirable.

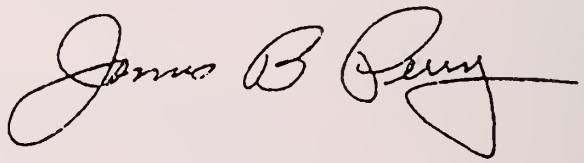
The physicians need the people and the people need their physicians. Let him who is without sin throw the first stone.

But then we don't need more stones; we need the good will of all men in order to come to a reasonable, appropriate and constitutionally correct answer to this horrible problem of the mid-80's decade.

It would be interesting if we took the lessons of Williamsburg to heart.

When the revolution started the people were under control of the governor. In their own city the solution that seemed to be so effective was several days of prayer and reflection with the necessary closing of all business. The time spent in asking the Creator for help and guidance in such difficult times was very refreshing. We should all begin to do this. Perhaps a few days before the legislative session is scheduled to meet would be an opportune time for a "day of reflection."

More things are wrought by prayer than this world dreams of.



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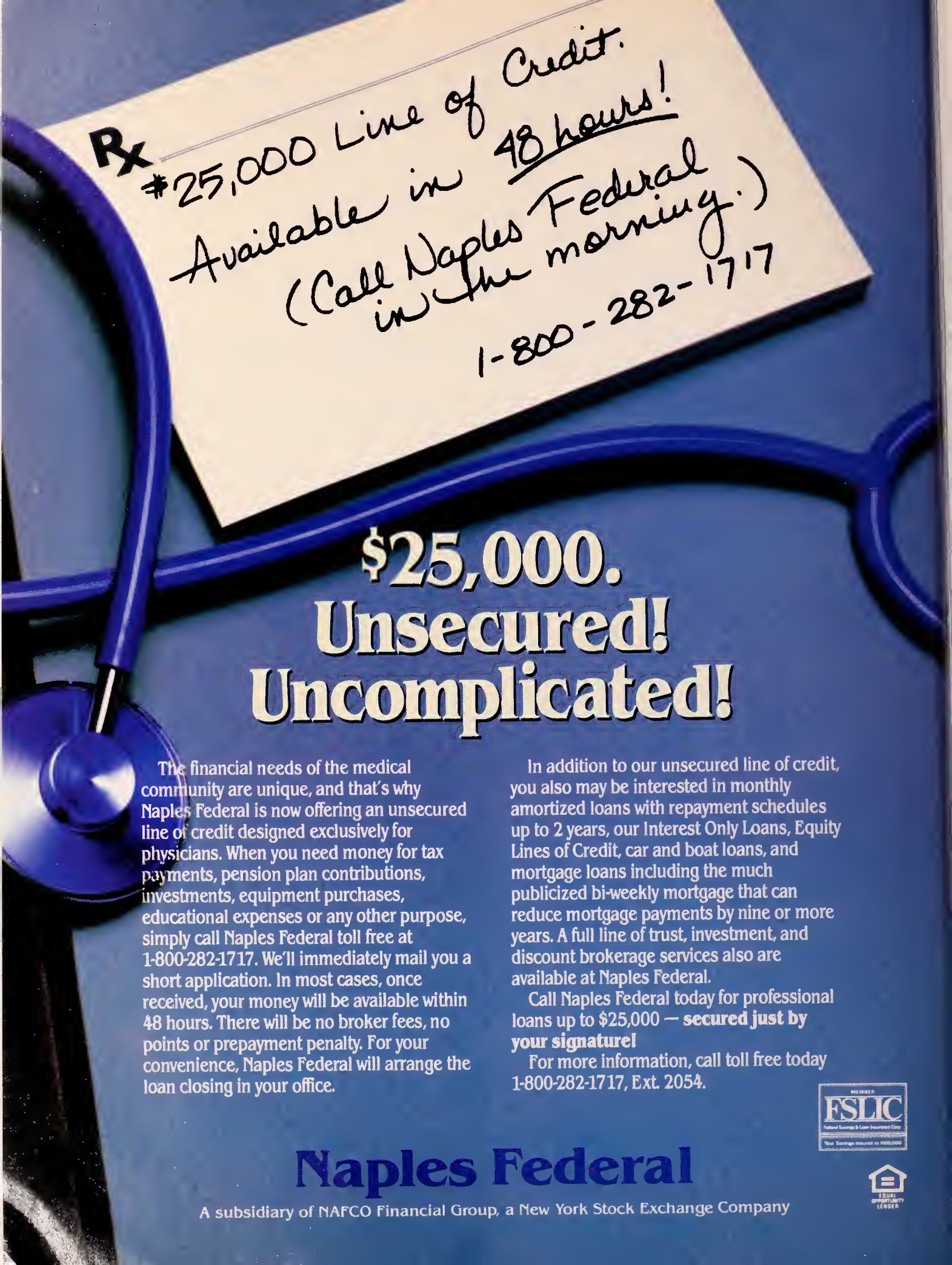
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EDITORIAL

Community hospitals: from the backwaters to the mainstream

Most community hospitals used to be poor second cousins to the more prestigious university medical centers. Even as they have done a creditable job in taking care of patients, their reputation was often nothing to rave about. Physicians practicing in these hospitals used to be derisively called LMDs, or local medical doctors, to distinguish them from their renowned academic colleagues. Even the ambitious attempts by many of these hospitals to upgrade their reputation by opening postgraduate training programs in the 60s and 70s did not succeed too well. Most American medical graduates shunned their programs, leaving most openings to foreign medical graduates whose massive influx during those years made them a source of cheap medical manpower. There was a perception somehow that the training offered in these programs was inferior.

But that bleak picture for most community hospitals is gone and the image has improved dramatically within the past several years. Spurred by medical advances of the past two decades and by a rising public demand for both basic and sophisticated medical care, many have come back as centers of excellence not only for patient care, but for post-graduate medical training as well. Their facilities are at least equal to their university counterparts, more modern in some instances, while community practitioners have become an eclectic mix of just about every specialty in medicine. People have forgotten about the town-and-gown syndrome and the terms LMDs has about disappeared from common usage.

Several things have transformed many community hospitals but two principal forces have been the advent of sophisticated medical technology and the big wave of highly trained physicians moving to many small and medium-sized towns and cities across the United States over the last 15 to 20 years. Medical technology, in many ways, has been a great equalizer; the availability in many community hospitals of CT scanning, sonography, MR imaging, angiography, open-heart surgery, and oncology has made it possible for community physicians to treat most of their patients without having to refer them to university centers or to distant multispecialty clinics like Cleveland and Mayo. Sophisticated technology, of course, demands skilled physicians, and they can be found everywhere in great numbers. The widely perceived glut of physicians has in many ways been a big boon to community hospitals.

One spin-off from these healthy developments in community hospitals has been the re-emergence of postgraduate training programs in many of them, and the strengthening of those already in existence for many years. As this special issue of *The Journal* clearly points out, many community hospitals in the state offer outstanding training opportunities for medical graduates in primary care and other specialties of medicine. Orlando, Daytona Beach, Pensacola, Jacksonville, and Tallahassee are among the well-known communities with hospitals that have been attracting young physicians from Florida and elsewhere for their postgraduate training and education. That these programs have been highly successful is evidenced not only by the large numbers of applicants but by their high quality as well.

The emergence of most community hospitals from the backwaters into the mainstream has been a salutary development in medicine. That many of them could combine excellent patient care with post-graduate training attests to their broadening role and reinforces as well the traditional commitment of the medical community to impart their art and knowledge to their younger colleagues. They may never replace the university medical centers, but they are coming close to them as models of excellence in every respect.

R. G. Lacsamana, M.D.
Editor



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The IMC-HMO fiasco: some painful questions

HCFA Secretary Bill Roper, M.D., says that he learned a lot from the problems that his agency experienced with the International Medical Centers HMO in South Florida, and that he won't allow similar mistakes to take place again. But why did it take HCFA so long to learn about the scandalous behavior of IMC, and why did HCFA continue to allow illegal activity to occur once it knew about it?

Why had HCFA decided to provide IMC with its first HMO contract when other more stable HMOs, such as Kaiser Permanente in California and others in Minneapolis and Milwaukee, had been in operation much longer and had demonstrated sound operations and fiscal responsibilities? Why did HCFA allow the use of official government stationery for a mailing to all individuals in South Florida on Social Security, urging them to sign up with the fledgling Medicare HMO? Is it the job of the federal government to endorse and advertise for a proprietary organization, such as IMC?

Why did HCFA allow medium and high-level government employees to leave government to work for IMC, the organization that HCFA was supposed to regulate? Why did HCFA establish rules that limit HMO Medicare enrollment to 50% and then allow IMC to have as many as 75% of its enrollment from Medicare patients?

Why did HCFA, despite articles in the South Florida Medical Review describing such activity, allow IMC physicians to perform pre-enrollment physicals on elderly Medicare patients at Medicare's expense, and then enroll only those who were healthy while rejecting those who were ill?

Why did HCFA, despite ample documentation over a period of several years, allow IMC and several other South Florida HMOs to use devious methods to enroll elderly patients, who often did not know that they had signed up with an HMO, and had signed away their rights to see other physicians or visit other hospitals?

Why did HCFA allow IMC to continue to use expensive advertised solicitations for elderly Medicare patients after they were expressly forbidden to enroll more Medicare patients? Why did HCFA allow IMC to continue to spend millions of dollars on expensive advertisements in Florida newspapers and on television and radio, when the HMO was already demonstrating evidence of financial instability and an inability to pay its financial obligations to physicians and hospitals? How could IMC be financially insolvent when its founder and chief operating officer, Manuel Ricarey Jr., was reported by the Miami Herald business section to have a net worth of more than $100 million dollars?

How could Congressman Claude Pepper (D-Dade) continue to defend and support Mr. Ricarey, even after Ricarey's indictment by a grand jury in Dade County, and after extensive public hearings by Rep. Dan Mica showed IMC's extensive abuses of HCFA dollars, patients' rights, and health care providers? Was Congressman Pepper instrumental in gaining HCFA support for IMC in the first place? For arranging the HCFA mailing to support IMC enrollment among the elderly? In continuing to allow IMC to break HCFA rules on Medicare enrollment?

What role did former Senator Paula Hawkins play, if any, in the favoritism shown to IMC? Why was her daughter a salaried employee of the HMO? And what about the other federal officials from HCFA who went to work for IMC: did their presence as employees of IMC influence HCFA's decision to look the other way for two or three years as IMC bent or broke the rules? What influence, if any, did White House officials have in the regulatory laxity shown toward IMC? Mr

Recarey was a large supporter of GOP candidates at all levels of government, including the President himself.

When I was on the State Board of Medicine, I remember a discussion that I had in 1985 with a member of the State Board of Nursing who had been offered a high level, and most likely a high salaried position as a nursing administrator with IMC. I told her that I thought she was wrong to accept a position with an organization that was rumored to be corrupt and truly uncaring about patients. She thought I was unkind in my remarks and she said that she intended to use her skills and influence to bring high quality health care to the IMC organization. I thought she was selling her title on the Board of Nursing to those at IMC who sought to purchase legitimacy by buying individuals in high places who could impress the public and the media with their credentials. Before this young woman had joined IMC, Mr. Ricarey had already enticed several physicians occupying key positions in medical politics to his organization including two past presidents of the Dade County Medical Association and an officer of the American Medical Association. He had also brought aboard an academic physician whose medical credentials were his ticket to respectability. Perhaps it was their unique and outstanding medical talents that encouraged IMC to specifically seek them out for these lucrative contracts. The rest of us knew that it was really their titles that IMC wanted and not really their medical skills. Titles lend a degree of legitimacy to even the most corrupt organization, even for just a while anyway. After she left the Board of Nursing, the young nurse, who signed a contract with IMC, I was told, was terminated. Was it because she lost her title and was no longer worth her keep?

I was hoping that State Insurance Commissioner Gunter and HCFA's Roper would dissolve IMC and send the 175,000 enrollees back to the fee-for-service medical sector, back to all the good and decent hard-working doctors who had opposed IMC's treatment of patients and physicians alike, we who had sensed its corruption from the start and who knew that IMC represented the worst that was possible in health care: the corrupt businessman squeezing patients and physicians alike in order to become selfishly wealthy and powerful, corrupting government officials, physicians, nurses, and hospital administrators along the way by the promise of large sums of money and a percentage of the take.

IMC was sold to Humana Corporation because, despite IMC's excesses, corruption, and inefficiencies, the government is determined to support HMOs and encourage their existence and survival. What a pity. I've read about individual physicians going to jail for defrauding Medicare or Medicaid of $2,500, yet HCFA paid IMC $30 million dollars each month and got very little in return. IMC today is being allowed to survive. What a pity.

Richard J. Feinstein, M.D.
Miami

Rep. Bell promises liability solution

I read with considerable interest the editorial in the June issue, "Contrasting Perspectives on the Malpractice Problem" by Dr. Frank Farmer. This was a very interesting and stimulating analysis of the different points of view on the subject of medical malpractice, medical malpractice insurance and tort reform.

My first reaction was to object to the way in which Dr. Farmer categorized the legislature based upon my own views. However, I must concede that when he speaks collectively about the legislature, he is correct.

I believe that we have a genuine problem that is going to require meaningful tort reform, a significant change in the system, and new mechanisms for insurance and payment of medical expenses. I have pledged to be a prime sponsor of legislation developed as a result of the Academic Task Force which is due to issue its report in March 1988. I sincerely hope that its recommendations are significant and that they can be implemented. In the meantime, I am fearful of what would result if the legislature were called into special session during the summer or fall of this year. It may be that the crisis will necessitate our taking some action before the next regular legislative session. Should that occur, I hope that our response can be limited so we could concentrate on significant long-term solutions during the upcoming regular session.

Thank you again for sending me a copy of the editorial and for sharing your perspective on the problem. I give you my personal pledge that I intend to work actively for a solution to this problem.

Samuel P. Bell, II
Representative, 28th District
Daytona Beach

Defensive medicine and the malpractice climate

I am writing in reference to Dr. Lacsamana's editorial published in the April 1987 issue entitled "Doing less and thinking more, or How to save more and order less." I agree with his opinion that it is appropriate for physicians to be more concerned with the cost of medical care and in making an effort to limit such costs by avoidance of unnecessary tests. This is certainly an ideal objective for us all.

I do feel, however, that you have not paid sufficient attention to the malpractice problem and the effect that defensive medicine has on all of our medical practices. You state "the fallacy of this indiscriminate testing is that it protects physicians more than it benefits the patients." I agree that this is in fact the case, and in the current climate where physicians, the American Medical Association and the Florida Medical Association itself are clamoring for improvement and relief from the current tort system, I believe that it would be foolish for any physician to neglect to protect his own interests should there be an adverse result. Physicians, not lawyers, should certainly set standards for medical practice as you state. However, sometimes those standards are subject to judicial review, and in the current climate this can be very deleterious to the physician and his medical practice. It may well be true that every chest pain does not deserve an electrocardiogram, but yet even the most atypical chest pain may, in a rare individual, represent myocardial infarction, and if indeed an individual were subsequently to die from such myocardial infarction, and the attending physician had not obtained an electrocardiogram, for whatever reason appropriate or inappropriate, this would certainly subject that physician to the potential of liability in the current climate of malpractice litigation.

Therefore, although I agree in principle that it is desirable to limit costs by avoidance of unnecessary tests, and whereas I also agree that there is potential for abuse when physicians may own laboratory equipment or facilities for diagnostic testing and therefore benefit monetarily from obtaining medicine studies, I feel, nevertheless, that his editorial has failed to take full account of the malpractice problem and the need for defensive medicine in the current climate.

Michael D. Danzig, M.D.
Ft. Myers

When will medicine take a close look at itself?

I would like to make a few comments on the editorial written by Dr. H. Frank Farmer entitled, "When will society let Medicine come in out of the cold," which appeared in your May issue.

To me it appears that the medical profession has worked hard to dig itself into the hole of poor standing in which it finds itself. Apparently, Dr. Farmer has the idea that medicine has never really been a part of "the proper social structure" and has not attained the status of the legal profession. First, I am not sure that the status of the legal profession is all that great nor shining, and secondly, Dr. Farmer should read a bit closer on his medical history. Through the 1950s the doctor in the community held, almost universally, a position of respect and esteem and good social grace. Since the onset of the high technology years in the '60s, our profession has become enamored of the many gadgets and toys and "work-saving" devices of the electronic age. With this involvement and the "high tech" rise the relationship of the doctor and his patient has seemed to deteriorate steadily. The human contact and willingness to spend sufficient time with the patient and the family has seemed to have evaporated. The ability or willingness to spend this time sorting out the signs, symptoms, and feelings which may be often vague and multitudinous, and doing the necessary detective work and evaluation, seems to have disappeared and been abrogated in favor of a computer—which is a useful tool, but does not quite yet have the personal capabilities of the human brain.

Specialization in the field of medicine is often decided long before the student has graduated from medical school, and the previous long-standing habit of doing some time in general medicine before deciding on or determining whether one is really fit for the particular specialty has disappeared from the educational pattern and process, often to the detriment of the individual physician. The loss or feel for medicine and the patient and his family has led to a generation of physicians interested in only a small portion of the anatomy, and this lack of general interest is felt by his patients who feel rejected by it. It should not be necessary to refer every symptom or finding that occurs in the line of treatment to another specialist when what has arisen, or occurred, may be an unusual side effect of the surgery, medicine regimen or an unusual reaction of the human body to the course of treatment.

Having myself been a patient and on the other side of the table, so to speak, this last year for some severe cardiovascular conditions involving surgery, and being unfortunate to react poorly to many of the new "fancy medications," I was amazed at the lack of concern of many of the professional groups when everything did not go according to the way the drug representative said it would go. Several post-op surgical complications arose, none earth-shattering, but they were passed off with a wave of the hand or another specialist was called in. The attitude of not wanting to talk to the patient about these things bothered me, and I talked to friends who were undergoing cardiac rehabilitation with me and were nonphysicians and they were also upset and concerned.

One of the most annoying factors was to be operated on by a surgeon who took everything handed to him and did the most perfunctory of examinations (?) before wielding his knife. The work of a "professional assistant" is *not* adequate in my book; the surgeon should do his own examination—unless the

assistant is smarter than the surgeon. As a physician, I was caught between the proverbial "rock and hard spot" and submitted as the surgery was deemed essential and the attitude left with me was one of take it or leave it, and take your chances.

I graduated in 1939 before many of the 'Young Turks' were born, but my classmates and I were instilled with the idea that we held the patients' destiny in our hands and were taught a posture of humanity, humility and of taking a real personal interest in the persons entrusted to our care; this was expected of each of us by our peers and our trainers. Patients often quickly lose respect for the doctor who tries to play "God" and who relegates the patient to the status of a car chassis on an assembly line.

I realize that many physicians justify their feelings because of the pressure of liability, oversight surveys, quality assurance and the like. They also find themselves in a time bind and the need for structuring as mentioned by Kay Hanley in the *FMA Today* (May), but a person in need of care cannot necessarily be fitted into a ten-minute time slot. A pat on the back, a smile and a short prayer given on the run will not satisfy today's patient any more than it satisfied those of 20 or more years ago.

Another reason for the breakdown complained of by Dr. Farmer may be attributed to the "so called friendly first-name basis" with patients. I wonder how many patients really like being called by their first names? I feel it worsens the respect that patients have for their doctor. Familiarity tends to breed contempt. I would also like to mention the fact that medicine has seemed to have oversold itself to the "American Public," especially in respect to what the profession really can or cannot do. As Galen said, "I dress the wounds, God heals them."

There is nothing religious about this statement—it only admits that doctors are human and have human limits, emphasizing the need for letting the body and nature do some of the healing process. Nature did a pretty good job in many respects for hundreds of thousands of years on her own and we still are quite ignorant of many of the basics for many of the bodily functions and actions, despite our fancy machines. A perfect world cannot be obtained and I am sure we would not like it if we got it. We may have abolished diseases of one type but many have reappeared in other forms with genetic transmutation and the like. So medicine is always going to be a puzzle. We have sold a regimen of health care to the general population to the point that they expect miracles and quick cures one after another. Many of our population have never learned what it is to be really sick and panic early—demanding the newest antibiotic and immediate recovery. A few years out of this country or some time spent without the sulfas and penicillin descendants might let people realize what sickness really is and how much they can do for themselves and let their own bodies do. I am not advocating really going back to the pre-war days but we have exploited our powers and the drug peddlers have exploited their wares so well that I often wonder who is treating the person—the doctor or the drug salesman. Also the general public has no real conception of the cost of what they demand and have sold them and become very rejected in attitude if they were asked to pay the real cost.

When the profession, to which we belong, really begins to take a close look at itself and what we really are doing, not doing, how much we really are caring about our patients as patients, and not cases, then we may restore ourselves to our proper place in society. Right now, I am afraid, we cannot call ourselves "physicians" in the time worn tradition, but rather salesmen of medical procedures and nostrums.

John T. Benbow, M.D. (retired)
Panama City Beach

Editor's comment: I have read with interest Dr. Benbow's letter in response to my editorial in the May 1987 issue of *The Journal*. I certainly think that much of what Dr. Benbow says is true and I can find no reason to argue about the things that have gotten the medical profession in hot water with the public. I think he is absolutely right that all the things which he had mentioned have not served us well and have antagonized the public.

However, my point was that we are not all bad. Many times we have tried to participate within the framework of society and in order to do that we have, in my opinion, made tremendous efforts in this respect. However, for the reasons which I outlined in my editorial we have not been welcomed or integrated in society on many of the occasions where we have attempted to do this. While Dr. Benbow is correct in his assertion that medicine has done many things which have irritated the public, he also seems to forget that medicine has attempted to integrate itself in society and has been rebuffed for various reasons. I think the reasons are self-serving to those elements of society which have led these rebuffs and do not serve the public or medicine well. This was my only purpose in writing the editorial.

I also must say that I disagree with Dr. Benbow in which he tends to imply that medicine was a part of society in the 1950s and was very well respected and revered. Medicine was a respected profession in the 1950s, but most of this was due to the fact that technology, which had come along in World War II, was credited to the medical profession. We were able to deliver medicine and life-saving miracles at a very low cost at that particular time in our history. The public gave the medical profession the credit and we, of course, accepted the credit. However, I do not think

we were really a part of society because at that time the medical profession held itself somewhat aloof which, of course, is not the fault of the public. In ending my response to Dr. Benbow, I still stand by my statements that many of the efforts on the part of organized medicine to participate and to integrate itself into society as a whole have been blocked. I still feel strongly that medicine should be a part of society as do many doctors and as I am sure Dr. Benbow does. However, at the present time I am afraid the atmosphere is so volatile and the dislike or ill respect for physicians is so great that no matter what we do, we are held hostage to an image of times past when we did not try to make ourselves a part of society.

I appreciate Dr. Benbow's comments and his thoughtful insight into the problems which have plagued medicine.

H. Frank Farmer Jr., M.D.
New Smyrna Beach

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DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period, the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

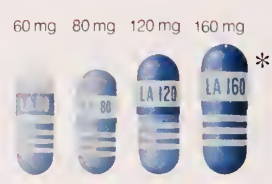
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

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WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, vivid dreams, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS — *Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily in angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE — *Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985, 145:1321-1323.

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In memoriam
Richard C. Dever, M.D.
1927—1987



Richard C. Dever, M.D., died June 18, 1987, as a result of a stroke suffered a week earlier. Dr. Dever, who was 60, was born in Jackson, Mississippi on February 16, 1927.

After high school, he entered Marion Institute in Alabama but his college education was interrupted briefly while he served in the Army in North Africa in World War II as a radio operator transmitting messages between Washington and Moscow. He later completed his undergraduate work at Millsaps College in Jackson, Mississippi. He then attended the Johns Hopkins University School of Medicine in Baltimore, Maryland, where he graduated with honors in June, 1952. He did his internship at Johns Hopkins from 1952 to 1953 and began his residency in surgery there. From 1954 to 1955 he was Harvey Cushing Memorial Fellow in surgery at Hopkins. He completed his residency at the Jackson Memorial Hospital and was licensed to practice medicine in Florida in 1958. Dr. Dever was a member of Alpha Omega Alpha and Phi Beta Kappa. He practiced medicine as a general surgeon in Miami for 22 years, primarily at the Miami Heart Institute and Victoria Hospital.

As a long-time Miami surgeon, Dr. Dever was active in the Dade County Medical Association. He moved to Jacksonville in the 1970s to become Vice President and Medical Director for Blue Cross and Blue Shield of Florida, Inc., a position which he held until 1986. Dr. Dever was Vice President of the Florida Medical Association during 1970 and 1971 and served on the FMA Board of Governors from 1972 to 1976 as well as on numerous Councils and Committees. He was also Associate Editor of *The Journal of the Florida Medical Association* for several years. He was a former governor of the American College of Surgeons, a member of the Florida Association of General Surgeons, and of the American Medical Association. He was an active member of the Duval County Medical Society for 11 years. He was Past President of the Dade County Chapter of the American Cancer Society and also served on its Board of Directors. He also served as a Vice President and was a Board member for the Coconut Grove Civic Club, was on the Board of Trustees of the Bartram School, and was a member of the Florida Yacht Club. Dr. Dever was also a boat enthusiast and was a member of the Ocean Power Boat Racing Association. During his earlier years Dr. Dever raced power boats from Miami to the Bahamas.

Dr. Dever published several articles including "Coronary and Carotid Perfusion Cardiac Bypass" which was published in *Surgical Forum*, "Treatment of Cardiac Arrest During Surgery" printed in *The Journal of the American Medical Association*, "Treatment of Penetrating Wounds of the Inferior Vena Cava" which was published in the *American Surgeon*. He also co-authored an article on "Acute Hemolytic Streptococcal Gangrene" which was published in *The Journal of Plastic and Reconstructive Surgery*.

Dr. Dever's contribution to building effective relationships with the Health Care Financing Administration, government officials and organized medicine will not be forgotten.

Dr. Dever is survived by his wife, Joan Burlingame Dever, and three daughters, Cecilia Ann Dever, Genevieve Richardson Dever, and Sara Dever Reed. Dr. Dever's family has asked that as a memorial, donations should be sent to the School of Medicine of Johns Hopkins University in Baltimore, Maryland.

PHYSICIANS, SCHEDULE SOME TIME FOR YOUR COUNTRY.

Many physicians would like to devote some time to their country in a local Army Reserve unit. We know that making a weekend commitment can be difficult for most physicians. So it is practical for the Army Reserve units to be flexible about time. It's worth discussing.

Incidentally, in addition to satisfying your own desire to serve your country, there are exceptional opportunities to do something totally different from a day-to-day routine. Opportunities to study new areas of medicine, meet new people in your specialty, and be a part of one of the world's most advanced medical teams.

Discuss the opportunities with our Army Medical Personnel Counselor.

FOR SURGEONS LOOKING FOR A CHALLENGE.

Your challenge could be the Army Reserve unit near you. It's a unit that requires the services of surgeons.

You may wish to explore the challenge of teaching in a major medical center. You may wish to explore the special challenges of your specialty in triage. Certainly you'll be confronted by challenges very different from your daily routine.

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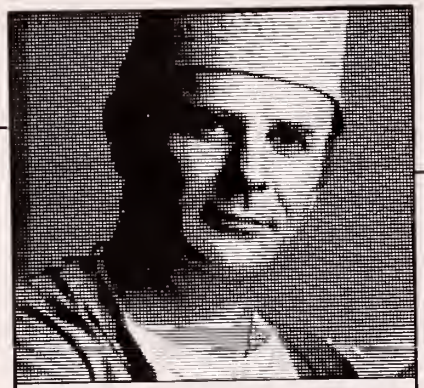
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
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A case for recent history

In this historical issue of *The Journal of the Florida Medical Association* we have elected to focus on graduate medical education in the state of Florida. This is being done for several reasons. First and foremost is that I could find no publication which offers a history of the different institutions which have graduate education. This is in itself is a propelling reason to attempt to give the story of graduate medical education under the cover of one publication.

There are, of course, many other reasons for this particular issue. I have attempted to get as many of the original participants who shaped the events of the various training programs and were in many instances present when the initial events happened. We have a story of the University of Miami from the first acting Chief of Medicine and from Jacksonville a resume of events written by a person who sat in on discussions which led to the JHEP program and who saw the political pressures in the inner battles between various interests which had to be overcome to establish a program. We have the director of the Family Practice Program at Halifax Medical Center in Daytona Beach who was not actually present at the beginning of the program, but who researched the records and had discussions with many people who were involved from the inception of the original program. All of these writers have written fascinating stories which will be appreciated by all the readers and especially those who were involved with the various programs.

In order to get personal participants, I have had to prepare this issue on the theme of "recent history." History is history and as a former historian I am well aware of the importance of recent history as well as remote history. I am afraid that history which has occurred over the past 30 years is sometimes suspect as "pure history." As historians and readers of history, all of us have at times immersed ourselves in history of two to three hundred years ago with much less time being devoted to the history of the past 30 years. Part of the reason is that proportionately the history prior to 30 years ago takes up a much greater share of history than the period since. Another reason is that we have come to view history as events and personalities which have occurred before our lifetime. In reality, the study of relatively recent events offers many advantages. It enables a historian to talk with the actual people involved. These interviews will offer a first hand view of the events as they happened and without this knowledge the story will lose something very valuable which may lend a different interpretation and viewpoint besides that given by the study of documents and third person accounts. When the participants pass on and their personal recollections are not recorded, a valuable historical resource is lost forever.



The most important reason in this particular historical issue for discussing recent history is that medical training programs in Florida are relatively new as all the programs in this issue have come into being in this century. So, out of necessity, to write about medical training programs in Florida is to write about recent history. However, as the reader can ascertain from this editorial, I put great value on recent history and can point to some of the great historical events over the past 40 years such as Korea, Vietnam and the establishment of Israel as a nation to buttress

my feelings on the importance of history in the last several decades.

I will let the reader decide what value these articles have in relation to the future direction of residency programs, but I think that for a clearer understanding of the forces that were at work in the formation of these programs, this issue will serve well. Also, the reader will see what forces have intervened to make some residency programs experience hard times and hopefully will give an appreciation of the various political pressures on the establishment and maintenance of any program.

Also, in this issue is a story of the Florida East Coast Hospital in St. Augustine which existed for 60 years and cared for thousands of railroad employees and their families at a price that is unbelievable even in the times in which the story takes place. It is a story of corporate medicine in which the employees were well treated in respect to medical care and a sense of paternal concern was evident.

Also included is an article by the dean of medical historians in the state of Florida, Dr. William Straight. Dr. Straight has, as he always does, written a very lucid and fascinating story of Camp Miami, a military post during the Spanish American War. Dr. Straight has researched original documents and new information, which he uses to tell his story in a lively and vibrant manner. The story of Camp Miami is a story of public health measures and attempts to fight infectious disease in a military setting.

I have endeavored to bring a story of every institution that has been involved in higher medical education in the state of Florida. Every institution was invited to participate and as you can tell by this issue, the vast majority of them chose to do so. For those who were invited and for some reason or another were unable to tell the story of their institutions, it is hoped that these stories can be told at a later date.

Hopefully, these articles on the history of medicine in Florida will provide informative and interesting reading and help to give some insight into the heritage of medicine in this state.

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor

Medical teaching in South Florida

How it started and how it got on its feet

Franz H. Stewart, M.D.

History rides a fast horse—a horse forever running, sometimes over stretching plains, again through thick woods, but always gathering new vistas and adding them to the old. An eyewitness can capture a vista and bring it to life because he was present and felt the emotions of the time. He cannot escape the coloring of his own life.

Recorded here are bits of memory, quotes from documents written to encourage participation in the beginning of the medical school, and to mark important dates and events at the time they occurred.

Medical teaching is a mutual learning process, a stimulus to questioning and problem solving, and a guide to humanity. This process is in progress in hospitals, in medical groups, in periodicals and in the every day life of each physician who strives to follow the life pattern of student and practitioner of the art.

When South Florida was a land of everglades, birds, animals and Indians, a few people clustered about the forts along the Miami River, Key West and Fort Myers; the Florida Medical Association began in Jacksonville. The next year, on February 17, 1875, "Dr. John P. Wall read an interesting and carefully prepared paper on *Preventive Medicine* which received marked attention. . . ." The Proceedings of the Florida Medical Association, April 1877, includes a scholarly paper by Dr. T.M. Palmer, *Medical History of Florida*. Less than ten years before this, at Ft. Jefferson on Dry Tortugas, Dr. Mudd, a physician, was held prisoner. During an epidemic of yellow fever, he established that an open free breeze was a protection from the contagion. Thus, Dr. Mudd may well have been the first clinical investigator in South Florida. Continued self-education is as old as the most ancient medical writings.



Origin disappears • The origin of the first accredited medical school disappears into the past. It began in dreams and aspirations and goes back countless years as the influence of one man carried on in the work of the next. Evidences of the origin can be seen as long ago as the late 1930s. Each Sunday morning for several years, meetings were held in the library at Jackson Memorial Hospital and were attended by doctors who shared a learning and teaching experience with each other. As many as 50 and occasionally 70 would appear and participate in these programs. Philip Rezek, having escaped the Nazis, joined me in these early teaching programs and began collecting slides for use in the medical school whenever it should come. There seemed little doubt that there would be such a school.

The moonlight and the shadow of piney woods beyond were uncanny. I stood and felt the aloneness of the evening. Someone spoke. It was Bowman Ashe, President of the University of Miami. This creative individual stretched out his arm toward the woods, "Do you see what I see? I see the buildings and the people of a great medical school. This would be a fine spot for it—maybe in another spot, but mark my words, it will be here!"

The Author
FRANZ H. STEWART, M.D.
Dr. Stewart was the first Chairman pro tem of the Department of Medicine at the University of Miami School of Medicine.

There was a decade of great excitement and energy. The horror of Nazism had exploded and died in its own bunker. Victory was complete in the Pacific and now individual Americans were left with a highly charged drive and confidence which had to be expressed. In South Florida this resulted in new projects and developments.

The teaching program at Pratt General Hospital ended when the Army discontinued the hospital at the old Biltmore Hotel. It was not long before the Veteran's Administration took over and a program started afresh. Ties with the University of Miami began and the staff of a research group began work.

New hospitals were built and developed from the work of the clergy, doctors, politicians and active citizens. Growth was everywhere! This was not limited to South Florida but the whole state shared in this enthusiasm. Jackson Memorial Hospital became the nucleus of increased activity and the focus of attention and effort from the large group of qualified physicians with the need to participate and to teach. This same drive and need appeared all over Florida. The time was just right for a medical school.

Miami was ready. The University of Miami was ready. The staff of Jackson Memorial Hospital would supply clinicians and teachers and the "Old Biltmore Hotel" would furnish space in former servants quarters. The research unit would begin work in the preclinical areas of the school. The state legislature was ready to lend support to a medical school.

There was a healthy rivalry in various parts of the state to become the first to have a medical school. Just as in any good football game, the competition became intense and the need to be first and so obtain state aid furnished the momentum. This seeming turmoil simply added determination everywhere.

The game gave Miami first chance but did not stop the development of two sister schools. Florida was ready and needed more than one medical school. The contest became a race for excellence, not priority. Many committees, various civic and political groups, medical entities and individuals were collected, not painlessly, to accomplish the support needed to start the school.

Dr. Homer Marsh arrived in mid-summer of 1952 as Associate Dean. The school was scheduled to start in September. He quickly assumed his many duties and lost no time in making faculty appointments for the preclinical studies. Some men were already working and preparations had been made for the class in anatomy.

The DCMA Bulletin of September 1952 published an editorial to welcome the school and introduce it to the doctors of the community.

"September Twenty-Second" ● "There should be no great excitement. Important developments mark important dates on the calendar only after time has added memory, satisfaction and pride. The mere opening date for a new venture does little more than arouse curiosity and speculation.

"The twenty eight who start on the twenty second will be measured by future years. These students will be remembered according to the humanity and the impetus to work and study that they carry from the school. . . ."

In November the feature article in the DCMA Bulletin described the fledgling school, its students and teachers:

> ". . . you will hear of our school. Some day you will meet graduates, and you will hear papers by members of the staff. . .but we hope the first thing you hear will be that the school turns out good doctors. . .
>
> . . .The physicians and surgeons of the community are a part of the school, just as the school is part of the community. The practice and the teaching of medicine are inseparable." F.H.S.

Students of the first class will remember the names of the these first faculty members: R.T. Hill, George Paff, Frederick Garrett, John McAnnaly, George Tershakovec. The freshman year proceeded well.

Early days of clinical teaching ● The curriculum called for instruction in physical diagnosis to begin with the second academic year. Dr. Marsh asked me to plan and organize this course. Seven physicians joined in this effort. They were Drs. Martin S. Belle, Francisco A. Hernandez, Louis Lemberg, Seymour B. London, Archie McCallister Jr., Wiliam M. Straight, and Jack L. Wright.

Medicine 500: Physical Diagnosis began at Jackson Memorial Hospital on September 24, 1953. The event was documented in *The Journal of the Florida Medical Association* with an editorial and a photograph of the students and faculty:

> "In years to come, as the pages of *The Journal* are turned back, this record will be found. The pages will show that all sections and all interests within the Association noted with pleasure this milestone in the development of medicine." F.H.S.

The Patient

His History and Physical Examination As a Guide to Understanding

Introduction ● A good doctor knows his patient, his background, his aims, his good points and his weaknesses. He listens inquisitively and patiently, yet precisely. He guides thought in directions which his judgment and experience tell him are most likely to

yield evidence of physiologic derangements. This is not easy and like any art requires understanding of situations, skills in the tools of the art, and a modicum of that intangible substance of which the artist is made.

The physical examination is done with kindness and consideration and always with an alert, reasoning and questioning intensity of observation."
(Written for the first class—F.H.S.)

In July, Dr. Marsh was recommending appointments in the major clinical departments to be ready for the junior year which was to start in September. I agreed to accept the Chairmanship of the Department of Medicine pro tem. It seemed best to seek a quiet mountain cottage in order to plan the program.

A letter came from the Dean:

"August 5, 1954

. . . as to salary, Jay Pearson approves of our discussion that it shall be at the annual rate of $16,000 which, as you know, is the rate for our full-time clinical chairman. You will be given the rank of Professor of Medicine and title of Chairman Pro-Tem of the Department of Medicine. In keeping with your expressed wishes, we will consider this as a temporary arrangement. . .

I should like to say, Franz, that I am deeply appreciative of your interest in us and am grateful that you are willing to take on the problem of the teaching program. If there is anything I can do between now and your return to Miami, please let me know. Our problems are myriad but I believe that the next few weeks will see a clarification of many of them.

You may be interested to know that Dr. Robert Lawson has reported for duty as Chairman of the Department of Pediatrics and is located at the Hospital. Dr. Farrell plans to arrive sometime between August 15th and 20th. . .

Sincerely yours,
Homer"

There was now the opportunity in the next two or three weeks to plan the courses that the students in medicine would take, decide who should teach them, and how best to help them go beyond the facts that they must learn, and reach for the high ideal, the aims and the humanity handed down from clinicians, teachers and investigators. There were qualified practicing physicians ready and able to carry on the program. This made the task lighter.

Back to Miami, and out to Jackson Memorial Hospital. There must be some place to work, at least a desk. Dr. John Farrell and I went to speak with Dr. Jacques Gottlieb, who offered a room on the second floor for the Professor of Surgery, and space for me in his own office on the first floor. Thus, the Departments of Medicine and Surgery found temporary lodging in the Psychiatric Institute.

The next afternoon, we drove to the University campus and picked up stationery for the three new departments. Having acquired a desk and stationery, things were ready to begin. A lady came up to my desk and introduced herself as secretary to the Professor of Medicine. She went to work right away, welcoming people, making apointments, taking messages and helping in many ways. There was a little problem. She could not use the dictating equipment, could not take dictation, and could not read my writing.

Jackson Memorial Hospital would never be the same again. Students were busy and circulated throughout the hospital in teams, each group accompanied by an experienced physician. The freshmen and sophomores saw patients each week and joined in clinical discussion. The juniors were given two lectures each week to furnish a guiding thread of continuity throughout the year to help correlate study and thinking as stimulated by ward work and to cover material not met at the bedside. On the wards, the students made rounds with the clinical teams treating the patients. They did a complete history and physical, and the write-up was corrected and criticized by members of the resident staff.

Four afternoons a week, the juniors met on the wards in small groups with a carefully chosen physician. At this time, a student would present his patient and the problems concerned would be discussed freely by other students and by the instructor. This critique taught the importance of going to the library to search for information to help answer questions and problems raised in the study of each patient.

The students attended and participated in the presentation of patients at the Combined Medical Conferences on Wednesdays, and at the Grand Rounds on Fridays. Distinguished friends lent a helping hand by coming as Visiting Professors to work with the students, and among these were Dr. Russell Cecil and Dr. Eugene Stead.

In January 1955 the school and its Department of Medicine were moving along full swing. Physicians of the community, chosen because of ability and willingness to serve, now joined the effort under the aegis of the medical school. There was an exciting spirit of cooperation and enthusiasm born of the innate need to teach, to share, and to belong.

Dr. John Milton became Professor and Chairman pro tem of the Department of Obstetrics and Gynecology, and once again the practicing physician did the job.

An article by Dr. Homer Marsh appeared in the DCMA Bulletin, July 1955:

"New Professor and Chairman, Department of Medicine • Dr. Ralph Jones Jr. has been appointed Professor and Chairman of the Department of

Medicine effective July 1st. He will succeed Dr. Franz Stewart. Dr. Stewart, who has organized the department for the Medical School, has returned to full time practice."

Time passed and the students excelled. There was a dinner meeting of the new members of the Honor Society, AOA, and it was my turn to make the traditional "Charge to the Initiates".

"I CHARGE YOU — Enjoy your achievement and take pride in becoming a member of Alpha Omega Alpha.

Do not rest on this! Membership will not answer one single question for you. It will not give solace or benefit to one sick man. It can help you realize that you must do well. The complacency of mediocrity is forever denied you!

You have started well. Catch your breath, but accept the challenge to go places! You will gain depth and breadth of knowledge from the scientific attitude. The facts you gain, however changing they may be, will serve you well. But, this is not enough. Understanding and humility come slowly, but to those few who persist, there will come a love of man and a closer understanding of life.

To some will come the reward of a full life, a rich life, and the making of a great human being. I charge you to strive for it."

At the dedication of the Medical Research Building in 1960, there were two distinguished speakers. Dr. John Talbot, Editor of the Journal of the AMA, said "I know that all of you are proud of your Medical School and this Research Institute. . . . I see no need for caution in predicting that this will be one of the great Medical Schools in the land." Dr. Francis Shmehl of the U.S. Department of Health, Education and Welfare, declared: "The triad of Medical School, physicians and the community is the basis upon which medical education is based."

Today, after 35 years, there are some 4,500 graduates who attest that the school has grown in reputation and acceptance. From a small beginning by a few men it has become a great school with an exciting reputation in teaching, patient care and investigation. It takes place among the great schools of the nation.

One graduate, Bernard Fogel, has served with the school for some 25 years. He is President for Medical Affairs of the University of Miami and Dean of the School of Medicine. His determined leadership and guidance for excellence is strengthened by humility and loyalty.

To me, it seemed natural that the early days had receded quietly into the unobserved past. There was an awakening from this idea in the kind letter from Dr. H. Frank Farmer Jr. requesting comments about the early days of medical teaching in South Florida.

Listen quietly and you may hear the voices of those who have brought the past to the present, who gave you stimulus, whose dreams and aspirations go back countless years as the influence of one man has carried on in the work of the next. Now among us are new faces, new names — people who are challenged to bring forth distinction to the future of our school until, in time, their dreams become memories.

History rides a fast horse, gathering new vistas and adding them to the old.

• Dr. Stewart, 4970 S.W. 78th Street, Miami 33143.

Attempts at cooperative approaches to graduate medical education — the saga of J.H.E.P.

Max Michael Jr., M.D.

An article in the May 1960 issue of the *Journal of Medical Education*[1] described "The Jacksonville Experiment in Medical Education," which was to test whether a disparate group of hospitals with their staffs, administrators, and governing boards could cooperate in the development of combined citywide residencies under a single administrative and academic umbrella. The goal was improved graduate programs. This meant giving up a certain status by some, an increased financial demand on others, removal of inadequate residencies from some institutions, identification and nurturing of good teachers, and the beginning of that dreaded "bogey-man"—the full-time salaried physician in community settings.

In the early '50s, Jim Borland Sr., an energetic, imaginative and tenacious gastroenterologist, began ruminating over the development of some type of joint educational program among several of the hospitals in the community. Many reasons for this were attributed to him—"to prepare Jacksonville to cooperate with the College of Medicine to be built in Gainesville;" "a Machivellian scheme by Jim Borland to get residents at his favored hospital;" "as a method of pooling educational activities in the community to make for efficient use of resources." Whatever his reasoning, he pushed ahead, involving many physicians with discussion and meetings, all duly recorded in



the "Red Book" currently reposing in the JHEP/Borland Health Sciences Library. The all-encompassing appellation of this working group was "The Joint Committee on Coordinating Resident, Interns and Nursing Programs." The initial forays concerned Duval Medical Center, St. Luke's Hospital and Brewster Hospital, across the street from one another, and naturals for such considerations. Ultimately, St. Vincent's Hospital, Hope Haven Hospital and Baptist Hospital (opened in 1955) joined the fold. A statement recorded in the "Red Book" in 1954 fairly well describes the objective of the group: "It is recognized that no single hospital in Jacksonville is capable of furnishing and maintaining equipment and personnel needed to operate it at peak efficiency, but that by pooling resources already existing in hospitals, Blood Banks and State Board of Health, that these, in large measure, could be secured. It is realized that practical consideration dictated some duplication; senseless parallelism defeated growth. The day of the small hospital is going." Additional discussions concerned the difficulty in getting firm commitments for teaching on the part of the practicing physicians. The following agreements were executed at that time by the governing boards and executive staff of the participating hospitals:

a. Subject to approval of inspecting authorities, residencies or internships may be combined by the hospitals as desired in order to secure education

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advantages.

b. Pay for the intern or resident may be allocated to each hospital as desired by the Administrative Board.

c. That interns and residents may be assigned from one hospital to another to secure the type of experience that could not be obtained from his own hospital

d. The hospital at the moment utilizing the services of the house officer would be responsible for remuneration.

Anticipating, in almost clairvoyant style, the many arguments, tribulations and accusations that would ensue, the "Red Book" contains—"to avoid misunderstanding, the following rules have and will continue to govern hospitals." These are in part: "Agreements will be sought only in endeavors which are mutually beneficial to the hospitals of Jacksonville. No efforts will be directed towards any objections which would involve loss of identity of the hospital or loss of control of the house officers, nurses or the hospital teaching programs by the individual hospitals. The immediate and primary objective is by cooperative effort to secure mutual assistance and the improvement in teaching which the hospitals individually cannot secure for themselves."

Several innovative features were undertaken during these early times. There were basic science seminars conducted by faculty members of the fledgling medical school at the University of Florida, and these were paid by taxing the hospitals; there were attempts at standardizing housestaff salaries; there was a beginning inventory of library holdings in the community. After several years of these maneuverings, plans were made and adapted for means of financing and for the formation of a workable governance. Incorporation under the laws of Florida occurred in 1958 at which time the first Executive Director joined the group. Upon incorporation, the name Jacksonville Hospitals Education Program (JHEP) was adopted.

In the bylaws of incorporation the purpose of JHEP was given: to develop and operate a coordinated program among the member hospitals for the training of interns, residents and fellows. Thus the first thrust was for the development of some type of coordinated residency programs.

Residencies • When JHEP was chartered and planning commenced in 1958 for some type of coordination of residencies, there were a number of accredited programs at several of the community hospitals, and there were deep seated emotional ties to individual programs. Duval Medical Center's staff was proud of its role as the "indigent teaching hospital;" St. Luke's boasted the first internship in Florida. This was at the time when programs could be approved for varying lengths of time. As an example, there was a Surgical program approved for one year; an Ob/Gyn program approved for two years, and a Medical program approved for one year in addition to the usual three years for Medicine, four for Surgery, etc.

The number of approved programs were: Internship, 4; General Practice, 3; Pathology, 3; Surgery, 3; Medicine, 3; Ob/Gyn, 3; Pediatrics, 2; Urology, 2. Several of these were marginal and were close to losing accreditation.

All teaching was done by volunteers—busy practicing physicians, often with multiple hospital assignments. The assumption was that consolidation of these programs of varying educational worth could result in a more efficient use of manpower, better utilization of special features of each hospital, and improvement in educational content. Plans were developed for an administrative set-up whereby each participating institution with residents would have input into the planning and operation of the proposed programs. Moreover, there was a need for a program director or "department chairman" to serve in a leadership role.

Certain attitudes needed change. Foremost among these were that house officers were in the hospital to do the bidding of the hospital and staff rather than to be educated, and that things had changed little from the time "when I was an intern."

The program in Obstetrics and Gynecology was the first for which a fully consolidated coordinated program was achieved. Even though it necessitated each participating hospital and its staff giving up some prerogatives, the physicians involved with planning approved it with enthusiasm.

The basic principle followed was that at Duval Medical Center, where there was no full-time staff, residents had little or no supervision and an excessively large patient population as compared to what could take place in the private institutions. Accordingly, the program as developed called for residents to spend their first year in private institutions, with the remainder of the three year program being divided between private institutions and the Duval Medical Center. It was anticipated that the first year in the private institution would give the residents a certain maturity and judgment by virtue of close association with the private physicians acting as teaching and, indeed, such was the case.

For a program director, the Chiefs of Service in the participating hospitals decided that this position should be filled by someone other than one of their group. Their selection of Champneys Taylor was a happy one, as he took the leadership role in recruiting housestaff, planning schedules, and setting standards for teaching by attending staff. He did not hesitate to remove a resident from assignment to an attending physician when it was deemed that the resident was being exploited. The residency began July 1, 1961, redeploying those residents already on duty in the various programs and recruiting additional residents to complete the complement. It was not as traumatic

as anticipated.

Frequent meetings of the program director and the hospital chairman was a most useful method of communications, and these have been continued.

The program progressed and proved to be a popular one. In 1969 Bob Thompson joined the staff at Duval Medical Center (to become University Hospital of Jacksonville in 1971 when it moved into its new quarters) as Chief of Service. He became chairman of the JHEP program or Program Director, a position he continues to hold.

Naturally many changes have occurred during the years. Early on an institution was dropped from the rotation because of a sparsity of specialists in that field and subsequent inadequate teaching. The numbers of residents and time spent at University Hospital increased significantly as full-time staff was recruited at that institution. In essence, whereas the private hospital dominated teaching and patient care assignments initially, presently the complete obverse is the case. This was to be anticipated and has had a salutary effect on the program.

Other JHEP residencies followed, with Pediatrics and Internal Medicine being next. Recruitment in Medicine lagged behind others, making "deployment" into hospitals difficult. There had been some exchange in Pediatrics between the residency at St. Vincent's Hospital and the one at Duval Medical Center, but no attempt at a unified city program until 1961. A senior resident, upon completing his residency in Pediatrics, was put on as "an instructor" and a $6,000 salary paid by the JHEP corporation. His time was carefully apportioned among the participating hospitals. This was a resounding success but generated much grumbling—"the foot is in the door," "there will be more full-time people," "they will cut us out of teaching," "the hospitals are practicing medicine." Had this ploy been undertaken 15 years earlier or 15 years later, the fears expressed by practicing physicians would have been the same.

Development of other JHEP programs, that is consolidating existing residencies into a single unified program, was done with varying ease and cooperation. Always, giving up some prerogatives caused consternation among hospitals and their staff. The "haves and the have not syndrome" appeared. Each program differed as to numbers, residents, hospitals utilized, length of assignments, teaching methods, and number of teaching staff. The basic principle followed by all was to utilize the features of hospitals that could contribute most significantly to residents' education. The hospitals' "needs" were to be subservient to the residents' education. Even at the outset and before full-time staff, Duval Medical Center (and later University Hospital) had the majority of residents in each program with a few exceptions.*

New JHEP residencies were commenced in Plastic Surgery, Orthopedic Surgery and Family Practice. Currently there are 222 residents and fellows.

Anesthesiology	1	Ophthalmology	2 (U/Fla)
Community Health	18	Orthopedics	8
Critical Care	5	Pathology	6
Dentistry	12	Pediatrics	23
Emergency Medicine	32	Plastic Surgery	2
Medicine	50	Radiology	12
Ob/Gyn	24	Surgery	27

A number of interesting and often perplexing problems have risen as the programs have jelled. At the inception it was proposed that residents receive a single check from JHEP, which in turn would bill the hospitals. This necessitated a uniform pay scale, difficult to accomplish because of the varying prequisites given. There was a question of social security, which at that time, could be optional on the part of an institution. Then there was the issue of who was the employer. The decision by the IRS indicated that the hospital was the employer and this did save the JHEP corporation certain administrative grief. Equalizing the allowances for meals, time for vacation, health insurance and later malpractice insurance were all issues that were addressed. Central housing was discussed almost from JHEP's founding. Apartments were finally secured and renovated in 1975. For many reasons this project was abandoned three years later.

The certificate at the conclusion of a residency is awarded by JHEP. The format has changed over the years as has the particular design. When JHEP was made an official division of the Health Center at the University of Florida, and when close relationships were developed with the College of Medicine, this relationship was noted on the certificate and the Dean of the College of Medicine became a signator.

The surveys of programs by the representatives of the various accrediting agencies are managed by JHEP and the listings in the Directory of Graduate Medical Education of Approved Residencies so indicate this.

A number of communities around the country have emulated part or all of the principles and, as to be anticipated, some were more successful than others. There is no question that many programs approved when JHEP began could under no circumstances have survived much longer. Stumbling blocks have been multiple, perhaps the major ones have been inflated egos, insecurity, and institutional parochialism. What seemed to be insurmountable mountains at the time they developed have faded into manageable, small molehills or have been totally destroyed. Obviously were one to begin anew, many lessons from past experiences would be quite helpful.

Currently more residents are at University Hospital. In this institution, in addition to a patient

*Initial program directors were: Ob/Gyn—Champneys Taylor, Pediatrics—Hugh Carithers, Internal Medicine—Karl Hanson, Surgery—Harry Remstine, Orthopedics—Hugh Haston, Urology—W. A. VanNortwick, Plastic Surgery—Bernard Morgan; Oral Surgery—Roger Hehn; Family Practice—L. E. Masters, Pathology—Ron Rhatigan.

population that has traditionally served as a "teaching nucleus", there are 101 full-time physicians devoting a significant part of their time to teaching.

Now, all Program Directors or "JHEP chairmen" are full-time physicians on staff at University Hospital. This has made possible better supervision and evaluation of programs. Programs have not remained static. They have been adapted to exigencies of the time as they arose, to changes in hospital philosophy and politics, and to changes in types and numbers of teaching physicians. Fluctuating relationships with the University of Florida have produced some changes, but not to such an extent as was anticipated. Buried in JHEP files is a letter of interest. It came from a staff member of the Council on Medical Education of the AMA early in the '60s. He was directed to write thusly:

> ". . . wished me to emphasize that this type of program is an important pilot program and it is important that all aspects as presented be lived up to fully by the participating hospitals. We feel that this type of program will be developed increasingly in other parts of the country, and that it is important, therefore, that it be successful and that it demonstrates that several hospitals can cooperate fully."
>
> Reluctantly one can philosophize that the era of cooperation among hospitals seems to be a fading illusion.

Governance • In his infinite wisdom, Jim Borland Sr., conceived of an organizational structure for a Board of Trustees that would be composed of the representatives of the varied interests of member hospitals. A member of the medical staff, member of the Board of Directors, and the administrator of each of the six participating hospitals constituted the initial Board of Directors. This 18-person group met monthly to consider various activities. Such functions as the establishment of citywide residencies, methods of paying housestaff, development of coordinated services such as libraries and laboratories, and development of continuing education programs were debated.

The Finance Committee was composed of the six administrators. This proved to be a rather unhealthy situation in that their major concern was "the bottom line," not education, and the objectives of the organization became somewhat dim. When this committee was restructured to include physicians and hospital board members, a veritable "cocklebur under the saddle" was removed.

During the ensuing years, the board structure was enlarged to include representatives from the Blood Bank, additional member hospitals, University of Florida, Duval County Medical Society, and local educational institutions. The board became large and unwieldly at one time consisted of 48 members. The first major reorganization involving board structure was accomplished after much study in 1977. This purported to give more representation to University Hospital, which had the largest number of residents, and to the Medical Society because of its physician members. Relationships with the University of Florida were enhanced and the Dean or his designee attended most meetings of the board. At this writing and after one of the several reorganizations, there are currently 11 members including one physician and one dentist. The remainder are leaders in the community with varying interests. It was thought essential by many that the president of JHEP be a physician. This was the case until the reorganization in 1977, since which time a nonphysician has served as president, and this has been salutary.

President have been: James L. Borland Sr., M.D., 1958-60; Samuel M. Day, M.D., 1961-62; Richard G. Skinner Jr., M.D., 1962-66; Karl B. Hanson, M.D., 1966-72; James L. Borland Jr., M.D., 1972-74; Donald R. Hagel, M.D., 1974-76; D. J. Lanahan, 1976-77; Roy M. Baker, M.D., 1977; Thomas G. Carpenter, Ph.D., 1977-79; Hobart Joost, 1979-81; T. O'Neal Douglas, 1982-85, and William O. Birchfield, 1985-present.

For some time it was urged that the governance of the board be vested in a nonpartisan group, or a group of civic leaders who are not particularly aligned to any institution nor any organization and who have a genuine interest in furthering the principles of medical education; in essence, a "junior board of regents type organization". The current board has many of these features.

Financing • The original JHEP annual budget of $32,000 was made up by hospital dues based on the number of patients admitted the previous year. As financial needs grew, so did hospitals' contributions. A grant from the John A. Hartford Foundation in 1961 was used, in part, to test library developments, to develop continuing education programs, and to test the feasibility of televising medical conferences through a "scrambling" system.

The first funds from the state legislature in 1970 were used to offset some administrative expenses, to develop library facilities and to expand continuing education. A grant from the National Institutes of Health was used to strengthen the cardiac catheterization laboratory at Duval Medical Center and to establish a blood gas laboratory and endocrine laboratory in the Blood Bank for use of the entire community.

Additional administrative costs and the need for enlargement of library facilities were several of the reasons for raising the amount of hospital contributions. The first significant increase in state funding made it possible to commence paying a small portion of the salaries of a few of the key full-time persons at University Hospital and to develop programs in cooperation with other colleges of the University of Florida Health Center. State allocations have in-

creased until at this time, of the total JHEP budget, $1,145,000 represents the state allocation and $209,600 the amount generated by corporation activities.

In 1981 University Hospital received an appropriation of $793,400 for creation of an additional 28 full-time salary lines and support. These monies are managed in the JHEP office, which by now, was recognized as the administrative center of the J. Hillis Miller Health Center in Jacksonville.

Relationships with the University of Florida ● JHEP, rather its ancestor (the Joint Education Committee), was in the throes of identifying objectives and defining its relations within its medical community at the time the University of Florida College of Medicine was in its early developmental stages. The first students entered the College of Medicine in September 1956 and JHEP received its charter from the state in March 1958.

When the first director of JHEP assumed the position on July 1, 1958 he was also appointed Clinical Professor of Medicine at the College. The "clinical" modifier created consternation in the usually orderly academic affairs hierarchy; to this day confusion continues over this appellation. The first class at the College began the course in Physical Diagnosis in September 1958 but Shands Hospital did not open until November of that year, thus students were given some clinical work in Jacksonville hospitals as well as in the VA Hospital in Lake City. Following this occasional students came to the Duval Medical Center for weekend work in the emergency room. Other than the previously mentioned clinical professor teaching weekly in the medical clinic in Gainesville, there was little interchange. When Regional Medical Programs were under discussion strong messages "came down" that the medical schools should make attempts at enhancing education in communities away from their home base. This marked the initial "interest" of the College of Medicine in Jacksonville medicine. The reasons were quite apparent.

In 1967 the director of JHEP was given the additional title Assistant Dean in the College of Medicine, and a formal document of affiliation was prepared. This culminated in the action of the Board of Regents in September 1969 recognizing JHEP as a division of the J. Hillis Miller Health Center. This document contained many features including mechanism of faculty appointments, plan for involvement in other colleges of the Health Center, and plans to seek legislative funding for JHEP.

Faculty appointments of the clinical type were given to approximately 20 of the practicing physicians who were active in resident teaching. When the full-time Chiefs of Service arrived at Duval Medical Center, "academic appointment" (absence of the clinical modifier) was conferred. With the designation of JHEP as a division of the Health Center, the Dean of the College of Medicine became a regular participant in the activities of the JHEP Board of Directors. As to be anticipated, increased state funding generated more interest on the part of the College in Jacksonville affairs. A myriad of issue involving the relationship of the two have arisen. Among these are management of a private practice fee, promotion of faculty, and the question of separate qualifications, and control of educational programs. Most have been solved but some still beg for solution. The state legislature called for a planning committee to work out the feasibility of University Hospital becoming a "clinical campus" of the College of Medicine; work continues in this area.

Medical students from the College of Medicine have come to the community in varying numbers and specialties. Usually there are approximately ten or 15 students at any one time. Regular assignments in Family Practice are made at the program at St. Vincent's. Most of the other rotations are on an elective basis. Ob/Gyn, Medicine and Emergency Medicine are the most popular. The number of students from the College of Medicine who intern in Jacksonville has increased steadily over the years. It has probably followed the pattern of their residencies in other comparable hospitals.

The 1969 document of affiliation called for developing relationships with other colleges at the J. Hillis Miller Health Center. A number of approaches were studied. In 1980 the Assistant Dean at JHEP was apointed Assistant Vice President for Health Affairs, indicating the new relationships. Increased legislative funding made possible the development of programs in the other colleges.

A division of nursing education, began in 1979, proceeded to assess community needs and to develop programs to satisfy these needs. Continuing education activities and a monthly publication listing educational opportunities as well as other pertinent materials were highly successful. But the most significant achievement was the establishment of course work, with the ultimate goal of awarding a Masters degree to successful candidates. Graduates who take all their course work in Jacksonville receive their degree from the University of Florida. Certainly this must be called the most compelling evidence of JHEP's "academic ties" with the University of Florida. Faculty for the program are from Jacksonville and Gainesville.

A highly successful JHEP Oral Surgery residency and identification of mutual needs has resulted in significant relationships between the JHEP Division of Dental Education and the College of Dentistry. A number of dental students receive some of their educational experiences in a recently opened dental clinic built jointly by the College of Dentistry and University Hospital. The local Dental Societies have worked quite closely with JHEP and have utilized features of the JHEP administrative structure.

Programs with the College of Pharmacy have passed the exploratory stage, particularly since the Pharm.D. degree, the terminal degree for pharmacy students in Gainesville, requires a significant number of clinical resources.

All of these relationships have been mutually beneficial, though the degree of the benefit might be subject to debate by each participant.

Library • The need for enlarged and more extensive library holdings was propounded early in deliberations of the "parent committee". There was no medical librarian in any of the hospitals, a rather scant list of journals and texts, and an unnecessary amount of duplication of holdings. These facts were stimuli for the establishment of a central library which began in 1961. This was to be a back-up for all hospitals in that it would serve as a the repository for older and seldom used journals and would subscribe to pertinent journals that were nonexistent in the "system". It was to be the center for reference material. The start was slow, particularly as the JHEP Finance Committee (at this time, all administrators) were loath to appropriate monies for such "frivolity." Moreover, it was difficult to convince some hospitals to transfer issues of journals past 20 years for storage—"the color of the bindings were chosen to fit into our library." The library was situated near the Medical Society away from hospitals. This principle of location has been said by several to be one of the reasons for success. It was not identified with any one institution and, thus, avoided suspicions and hostilities often precipitated by such association. Holdings were enhanced by grants from the National Library of Medicine. New services were offered. Donations from the medical community and from some physicians were essential for operation. A Medlars terminal, the precursor of Medline, was placed in the library and the medical librarian assisted hospital libraries in improving their operations. Currently the JHEP library carries the quite appropriate name of Borland Health Sciences Library and subscribes to 570 journals, contains 28,000 books and monographs and 4,000 audiovisual items. In addition, it catalogs all acquisitions from member hospitals.

This system represents a true consortium and has been cited as a significant prototype that set the pattern for the Regional Library Network of the National Library of Medicine.

Now the holdings in the Borland Library, as well as those of all hospitals, are on line with the University of Florida Health Science Library; thus the holdings of the library in Gainesville are easily accessible through sophisticated electronic networks.

Some significant changes in medical education • During the nearly three decades since JHEP was founded there have been a number of changes in graduate medical education both in form and substance. Those of special interest to this discussion are outlined briefly.

The consortium idea of graduate medical education was pioneered by JHEP. Since then many communities have emulated features of the program utilizing in the main features of more than one institution for the development of a graduate program.

The Coggeshall Report from the Association of American Colleges in 1964 urged and predicted a closer tie between medical schools and community hospital educational programs. The medical schools, the report states, must and should be the dominant feature in graduate medical education. Increasingly, various commissions and study groups have urged the complete direction by medical schools of all graduate medical education. JHEP has, from its inception, worked quite closely with the University of Florida in encouraging close association with the residency programs. Exigencies of time and political pressures have dictated many of these courses. Attempts to form single programs with a single program director between the two institutions have been difficult to achieve because of many logistical problems.

The escalating costs of doing business have not spared graduate medical education. From salaries of $150 a month to a nearly twenty-fold increase is only one of the features of escalating costs. The fringe benefits for house officers including health, life, and professional liability insurance are a part of this package. The ever-increasing demands of chiefs of service to increase their house staff complement forced many hospitals to put ceilings on the number of house staff; many have abandoned graduate programs completely. This is quite a difference from the halcyon days (or were they?) when hospital administrators wanted "more."

The saga of foreign medical graduates, both American and foreign born, is another of the issues confronting graduate medical education. At the inception of JHEP there were occasional foreign graduates in the programs. The number increased as the flow of foreign graduates into the country increased. The larger number of graduates from American schools, tightening of state and federal laws, and the many questions of various accrediting bodies have resulted in a dramatic decrease in the number of foreign graduates entering programs each year.

The JHEP program has not been without involvement with the thorny issues of the American students in Caribbean medical schools. This problem still faces graduate medical education and it is safe to predict that any "solution" will be political.

The increasing specialization and compartmentalization of medical practice has made its impact on all graduate programs. "The specialist replicates himself." Clinical fellowships, formerly the sole province of medical schools, have blossomed in many community programs and JHEP residencies have trained its fair share of fellows.

New disciplines have been created. Most notable

has been the development of Family Practice as a specialty with its own certifying boards. Emergency Medicine soon followed and a residency developed at University Hospital was the first in the state. It later came under the JHEP umbrella.

In 1975 "free standing" internships were abolished. This, contrary to the belief of many, did not abolish the first year of internship. It integrated the internship into the residency as an educational unit and abolished the lone internship without relation to a residency.

Moonlighting was a strictly taboo feature of most residency programs in 1958. Through the years because of varying financial pressures, family obligations and debts amassed in medical school it became more prevalent, even in some of the formerly "lilly white" programs.

Other changes that are difficult to detail have been rather striking. The attitudes of graduating medical students, of practicing physicians toward housestaff, and the hospitals' perception of their role in education have undergone many changes, often salutary. One other noticeable change has been the politicising of medical education. Not only has this involved payment schedules and budget, but also the determination of number of physicians to be in a given specialty and, indeed, the types and number of specialties that should exist. All of this could have been anticipated because of increasing costs, the general acceptance that health and its congeners is a right rather than a privilege, involvement of more hospitals, and the realization of government officials that they are dealing with a valuable resource for the country. On the local level, JHEP has not been without various political influences—both positive and negative. Political maneuvering among hospitals and staff has often been frustrating.

Conclusion • That the Jacksonville Experiment — JHEP— has been a success is attested by several facts. The corporate body exists, albeit with a completely different structure and function from the original; further more residencies remain under the JHEP rubric, and this whole cooperative mechanism has been emulated by many.

Obviously there have been enormous changes of philosophy and of programs, and of activities and inter-institutional relationships since 1958, but the basic principle of cooperative approaches to education persists.

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Halifax Medical Center

Evolution of a family practice residency program

William G. Tomson, M.D.

In response to community needs, Halifax District Hospital was formed by creation of a hospital taxing district in a bill submitted to the state legislature on June 4, 1925. The hospital was dedicated January 3, 1928 with 20 physicians and four dentists on the medical/dental staff. In its first year of operation, the institution recorded 19 deliveries, 1,418 admissions, and 567 major and 35 minor surgical procedures.

Dr. George Green, a graduate of the University of South Carolina, was the first "house officer" and the alumnus of what was destined to be a teaching program that would produce physicians who would serve as medical practitioners throughout the country. Almost four decades later, this institution would become nationally recognized for education in the specialty of family practice.

The Family Practice Residency Program at Halifax Medical Center was accredited in 1971 by the then recently formed American Board of Family Practice. This development evolved from a long-standing commitment on the part of the medical staff to progressive medical education. As a result of the foresight and persistence of a core of physicians dedicated to providing the highest possible standards of patient care and postgraduate physician training, our residency program was born. However, the road to what was initially promoted as "a new innovative program" was a long and difficult one.

The present medical/dental staff totals 280 with eight dentists. The hospital has grown to 545 beds with 19,932 admissions and 2,299 deliveries annually. Each year 6,201 major and 3,652 minor surgical procedures are performed. The Emergency Department sees 51,605 patients and is now a regional level II trauma center with access to a level II neonatal ICU.



Evolution • After the United States' entry into World War II on December 7, 1941, the U.S. Army assumed control of Halifax District Hospital and used it as support for the Women's Army Corp base in Daytona Beach. Later it became a convalescent and rehabilitation hospital for treatment of combat related psychiatric disabilities. It was returned to the community in 1946 to resume its role as a community hospital.

Dr. A.M. McCarthy, a native of Michigan and graduate of the University of Tennessee College of Medicine, arrived in Daytona Beach in 1946. A member of the American College of Surgeons since 1933 and certified by the American Board of General Surgery in 1937, Dr. McCarthy had served in the European Theater performing surgery for two years. This leader in the medical community lobbied very strongly in favor of further developing Halifax District Hospital as a teaching institution and medical referral center. He was one of a handful of early staff members with the vision to foresee the importance of family practice training to the quality of medical care in general and to the Hospital in particular. For a period of six months in 1964, Dr. McCarthy assumed the position of interim Executive Director of

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Halifax Hospital. For that service, he was paid $30,000 which he donated to medical education in the institution. This legacy provides for an annual award bearing his name for both the resident staff and attending staff for excellence in publication of medical research papers.

Records are scant for the decade following the post World War II transition from armed forces control to civilian operation but a two year general practice program of training with a rotating internship of one year was begun in the early 1950s and was continued through the 1960s.

A number of physicians now practicing in the community are alumni of this initial program. It was supervised by the medical staff but had no central direction, little didactic teaching, no research, and limited potential.

In 1956 Dr. Herbert D. Kerman came to Daytona Beach from the faculty of the University of Louisville to lead the Radiology Department. Being strongly interested in both patient care and quality physician education, Dr. Kerman realized that the training program at that time should be dramatically improved. In 1964 he was appointed chairman of a fact-finding committee charged with investigating and making recommendations regarding appointment of a full-time Director of Medical Education to coordinate all postgraduate medical education programs.

The committee affirmed the need for this position and set goals for the program. It charged the program with providing the highest possible standards of patient care, together with maintaining the equally high standards of medical education. In addition to the training of resident staff, the Director was responsible for providing continuing postdoctoral education for the medical staff.

The Director of Medical Education was to be directly responsible to the hospital administration and the medical staff through a Postgraduate Medical Education Committee composed of department chairmen, service chiefs, and representatives of the administration.

Although the initial concept and proposals of Dr. Kerman's committee were ratified by the general staff by unanimous vote, much controversy arose over the practicality of implementing the program. There was concern on the part of medical staff members regarding the quality of residents that might be attracted as well as the standards of education and the extra burden that would be placed on the staff by their new voluntary teaching duties. Mired in this controversy, Dr. Kerman in March 1968 pursued his goal of improvement in postgraduate medical education with little progress. He approached Dr. Emanuel Suter, Dean of the College of Medicine, University of Florida, at Gainesville, for assistance in restructuring the program. By July of that year, after having Dr. Suter examine the institution, Dr. Kerman was given a lengthy list of necessary conditions for the creation of a program to be acceptable to the newly forming American Board of Family Practice. With these criteria in hand, and many tense and trying medical administrative and political battles won, he began the conversion of the G.P. program into a family practice program.

The first step was selection of the Director of Medical Education. Dr. William Hubbard, a Duke University graduate from the Tampa area, entreated prospective resident applicants to reject the classic specialist medical discipline and become one of the 10% of physicians trained to treat 90% of medical problems and join his new program

At this time, the "new specialty" of family practice was just being officially sanctioned by the Board of Medical Specialties after much political lobbying by groups of generalist primary care physicians throughout the country. The year was 1969 and Halifax Medical Center began its Family Practice Residency Program with one resident, Robert Wyman, M.D., from the University of Michigan. It was the first official year of existence of family practice as a specialty and Halifax Hospital was the first community hospital in Florida to have such a residency program.

Dr. Kerman's dream of upgrading the quality of postgraduate education and patient care in Volusia County was finally realized. He would pioneer other innovative changes in the medical care delivery system in the future, the most notable of which would be the nationally recognized Regional Oncology Center.

Dr. Hubbard now had the difficult task of bringing about full conversion of the old G.P. program to a fully accredited family practice residency. A man of great enthusiasm and theatrical wit, the Director possessed a somewhat flamboyant personality which aided him in his teaching tasks. He would often "dress for the occasion" showing up in full safari garb, complete with pith helmet, to lecture on tropical diseases.

By March 1971, the residency program had been approved by the AMA Division of Medical Education and was in full bloom. In August 1973, Dr. Hubbard left the program to assume a practice in Dunedin, Florida, turning over the directorship to Dr. Richard W. Dodd with eight residents in his charge. Dr. Dodd was a man of tireless energy who displayed wizardry in management. During his tenure the Foundation for Medical Education was formed in 1973 providing a nonprofit entity to employ teaching physicians and promote, support and foster medical education, patient care, and delivery of health care services in the community at the undergraduate, graduate, and continuing medical education levels. This educational foundation was made possible by the financial support received from the medical staff and Board of Commissioners at Halifax Medical Center and was also one of Dr. Herbert Kerman's innovative ideas.

In the 11 years between 1973 and 1984, Dr. Dodd had accumulated impressive financial support in grants as well as raising the residents roster from eight

to 18 and recruiting an outstanding full-time faculty.

In October 1976, Dr. Dodd was joined by Dr. Brian Blaxall, former Director of the Family Practice Residency Program at St. Vincent's Hospital in Jacksonville. Dr. Blaxall was board certified in internal medicine and served as Associate Director of the Residency Program at Halifax.

Dr. Blaxall was a teacher loved by all. From the lowest man in the hierarchy, the intern, to the chief executive officer of the hospital, all knew this man's kind nature. Dr. Blaxall, a victim of poliomyelitis, in childhood, dedicated himself to the service of man in the practice and teaching of medicine. Suffering himself, unknown to his friends and colleagues, from muscular dystrophy, he chose to work with terminal patients as an oncologist. He was the embodiment of the principles of the Hippocratic Oath. A socratic teacher with a philosophical bent, Dr. Blaxall was the closest adherent of the Oslerian spirit that could be desired. He had the capacity to correct the grossest errors in the most acute and threatening clinical crisis in a manner that left everyone feeling comfortable. He left the program July 3, 1981 and died April 15, 1982 of his longstanding disease in St. Vincent's Hospital in Jacksonville, the location of his old program. In his honor, the Hippocratic Oath is distributed to our graduates and an annual award, started by him, continues to be given to the best motivated and most improved graduate resident who enters a family practice career and best exemplifies those characteristics of a physician noted in the Hippocratic Oath.

Dr. Dodd enlisted Dr. C. Michael Schwartz, a graduate of the program, as Family Practice Center Director from 1974 to 1979. He further expanded the faculty with the resources of Dr. Y. B. Auyeung as part-time pediatric faculty from 1977 to 1980. Dr. Nelita Ano was half-time Director of Behavioral Sciences from March 1978 to May 1980.

In the summer of 1979, the faculty was expanded to further meet the American Board of Family Practice requirements. Dr. Kathleen Santi, an experienced family physician with one year of Ob/Gyn training, became the program's coordinator of this area of education. She served in that position until 1983 when she left for private practice in North Carolina.

Dr. William Tomson, a family practitioner with interests and training in sports medicine, was recruited from Canada in May 1979 as Assistant Director and Program Coordinator.

Jim Branch, M.S.W., filled the clinical social work position vacated by Mary Markvart.

At this time, the program also had a full-time dietician position funded and Susan Beagle was convinced to switch to family practice from the hospital Dietary Department. With the volunteer teaching of the medical staff, the faculty was now complete and in compliance with the newly evolving guidelines. It had the manpower to achieve the original goals of excellence in health care delivery and medical education.

With sophisticated skill and negotiation, Dr. Dodd elevated the program to a position of national respect. In December 1980, after much planning and negotiation, the program was relocated in a newly renovated area of the hospital with greatly enlarged and modernized facilities. The new center had two clinical wings, each with a nursing station, surgical treatment room, and dictation area. One wing had seven examining rooms, the other six, plus a large family counselling room with an adjoining observation room equipped with video taping equipment for teaching.

Dr. Dodd and Dr. Hubbard had been both Director of the Family Practice Residency Program and Director of Medical Education. Halifax Medical Center had now grown to the point where these tasks were too great for one man. On the recommendation of the Residency Review Committee, these positions were separated and Dr. Dodd assumed the position of Director of Medical Education full-time.

Dr. Bernard Breiter, who had joined the program in 1979 as the Family Practice Center Director, a graduate of LaVale University in Quebec, Canada, was an experienced teacher, administrator, and practitioner. He agreed to succeed Dr. Dodd as Program Director.

During his directorship, Dr. Breiter worked to create more changes in the program. His personal interest in practice management provided much lacking experience in that area, which is only now beginning to be replaced with great difficulty. He sought and acquired approval for the hiring of two new faculty members. Dr. Richard Hartmann, a board certified pediatrician, came from Bartow, Florida, to become the program's Pediatric Coordinator. This position he has occupied to the present time serving also in the difficult area of neonatology in neonatal ICU. Dr. Anthony Dede, a board certified obstetrician/gynecologist, was lured from a busy practice in Montana to be coordinator of this area.

Both of these physicians brought boundless enthusiasm, welcome negotiating power, and credibility in their departments as well as much needed resident teaching and supervision in these areas of special expertise. Common problems in areas of internal medicine, pediatrics, and obstetrics and gynecology were thus effectively solved by respected members of those departments who were also faculty members, a distinct advantage for any program.

Dr. Breiter retired in June 1985 and Dr. Tariq Siddiqui became Director of the Residency Program. A graduate of Dow Medical College in Karachi, Pakistan, Dr. Siddiqui is board certified in internal medicine, hematology, oncology and board eligible in cardiology. A voracious reader, Dr. Siddiqui is as at home speaking of the Renaissance or the fine points of Egyptian mummification as he is conversant regarding contents of the last issue of the *New England Journal of*

Medicine.

Dr. Siddiqui had joined the program July 1, 1981 to fill the position vacated by Dr. Blaxall and continued to perform this duty while he was Director of the Family Practice Residency Program. A man of widely varying interests, he has recently left the program to serve a fellowship in Gainesville at Shands Hospital in bone marrow transplantation. He is also studying flying at the same time while commuting regularly to Daytona Beach to see his family, an indication of his incredible energy level.

On September 1, 1986, Dr. Siddiqui relinquished the directorship of the program to Dr. William G. Tomson, a graduate of the University of Toronto Faculty of Medicine and the McMaster Program at Hamilton, who had served as Family Practice Center Director after Dr. Breiter assumed command of the program.

Current status • The current faculty includes Dr. Lisa Reimer, who graduated from the program in 1980 and returned as a faculty member after a fellowship in nutrition and family practice teaching at Wayne State University in Detroit; Dr. Richard Branoff, who graduated from the program in 1981 and returned as the Family Practice Center Director and Associate Director after six years in private practice in the Ormond Beach area with a special interest in emergency medicine; Dr. Neil Benson, a graduate of the program in 1986 and winner of the Blaxall Award with a special interest in internal medicine; Dr. Walter Durkin, who has taken Dr. Siddiqui's place as Internal Medicine Coordinator; Dr. Richard Hartmann, Pediatric Coordinator; and Jim Branch, M.S.W., Director of Behavioral Sciences. We are recuiting for a new full-time dietician since Lisa Sixma and Susan Skelley will be leaving for the far more demanding careers of motherhood in June.

This year the program has enjoyed the best resident applicant match in its history acquiring the top nine of its submitted list. We have undergone a RAP consultation with quite favorable reports in preparation for the upcoming Residency Review Committee examination. We are fortunate enough to enjoy both the philosophical and financial support of both the administration and the medical staff in the pursuit of excellence in education.

Future plans • With direction from the Postgraduate Medical Education Committee presently chaired by Dr. James Carratt, and cooperation and financial assistance of the administrative staff, our program continues to add new patient services such as flexible sigmoidoscopy, colposcopy, and biofeedback services to assure our residents of the most contemporary clinical education possible.

We hope to broaden the program's scope in the future adding new areas to the curriculum such as geriatrics and community medicine, and establishing nationwide and international connections for exchange of information and personnel to enrich the experience of both faculty and residents. The scope and volume of patient's problems, and the resources of the program, should provide for research in patient care, physician education and clinical trials to foster contributions to the medical literature.

Products of the program • Although the greatest number practice in Florida, we have graduated residents who are serving both urban and isolated areas within the United State from California to New England and from Canada to the Gulf Coast. Outside the United States, we have sent many physicians off to isolated missionary work as far away as Zaire.

Sixty-four physicians have graduated from the program, four of whom entered before full accreditation. Since the program was officially sanctioned by the American Board of Family Practice, 58 of the 60 graduates have become Board certified. Forty seven of these graduates are in family practice with three holding positions as full-time faculty members in our program. Thirteen of the alumni are working in emergency departments with one recent graduate employed full-time in the Sports Medicine Clinic in Seattle, Washington, a nationally renowned facility in this area.

Forty-eight physicians or 80% of our graduates are practicing in Florida, with 20 in Volusia County. The remainder are distributed throughout the country and around the world. Halifax is thus achieving its goal of educating family physicians to answer the primary care manpower needs for the region and state.

Our residents are not triage officers, they are family doctors in the truest definition of this term. They are capable of managing the most acute problems, even in extremely isolated circumstances.

We are proud of Halifax Medical Center's record in the pursuit of excellence of education. It is the intention of the present faculty to create the best possible environment for education and to select only those candidates motivated to take full advantage of that environment.

Our annual family practice refresher course, started by a former graduate of our program, Dr. Roger Murray, while training under Dr. Dodd's regime, is a forum of family practice. It has been one of the most successful presentations of its kind in the nation. The Conference on the Beach, in its 8th year, provides 24 hours of CME credits for family physicians throughout the United States and Canada. Held in February, immediately following automobile races at Daytona International Speedway, this conference has utilized internationally renowned speakers presenting the latest development in primary care medicine. Booked well in advance, each year we welcome 200 family physi-

cians including many repeat registrants.

The conference adjusts to the changing needs in family medicine and the written requests of those attending. Last year, risk management as well as office procedure workshops were added. The reception was enthusiastic and we expect to expand this format next year.

We hope to duplicate this success by adding other specific conferences to our agenda in the coming years. Dr. Reimer has already begun this process with a smaller conference in practice management offered to members of our medical community as well as statewide which, thanks to her planning skills, will probably be an annual event.

Conclusion ● From a modest beginning, the medical staff of Halifax Medical Center has shown a consistent dedication to progressive medical education and excellence in health care. In spite of the many complex political and philosophical differences that occur in a multidisciplinary medical institution, the principles of quality in medicine and excellence in education remains a universal goal.

Through the efforts of many energetic and visionary staff members, our program has been transformed from a rudimentary rotating internship through the transitional general practice residency to its present state as a respected Family Practice Residency Program. It is now nationally recognized for excellence in education. The varied geographical distribution and the clinical success and scope of its graduates continue to attest to that fact.

Acknowledgment

I would like to acknowledge the assistance of the following individuals in preparation of this paper: Dr. Thomas Scott, Dr. Arthur Schwartz, Dr. Robert Stevenson, Ms. Alice Massfeller, Ms. Joanne Chandler, Ms. Kim Ikeler, and Dr. Herbert Kerman, and in particular his secretary, Ms. Connie Bates, without whose patience this paper could not have been produced.

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The Florida East Coast Railway Hospital: A study of early corporate medicine, 1906-1963

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To the best of my knowledge the Florida East Coast Hospital Association was established in 1906 to provide hospital, medical and surgical service to employees of the Florida East Coast Railroad and their families. A wooden building was constructed at that time and during a period of high employment while the railway was being double tracked three other buildings were added which housed patients and later were used for storage. The Association was controlled by a Board of Directors which initially consisted of four of the general chairmen of the labor unions and by employer representatives who outnumbered the labor employees. The charter called for a self-perpetuating Board of Directors, which met annually and elected an executive committee of three men who in effect managed the Association. One of the employee representatives was the chief financial officer of the railway company who actually controlled the financial affairs of the Association. The railway made up the annual deficit and for this reason felt justified in its control over the financial affairs of the hospital, upkeep of buildings, furnishing of supplies, and instruments.

Editor's note: This article resulted from a conversation with Dr. Lockwood who served as Chief Surgeon of the Florida East Coast Railway Hospital from 1930 until 1963. It is in his words and tells a fascinating story of a hospital in an era that is being rapidly forgotten.

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Originally, the contribution of each employee was $1 per month deducted from his pay and from which he received practically full hospital, medical and surgical care. About 1927 the contribution was increased to $1.50 and dental care was added. It only took a couple of years to realize that dental care was costing more than medical and hospital care and for this reason it was discontinued, although the contribution continued to be $1.50 per month. The Association was advised by the Chief Surgeon of the railway, who acted also as the administrator. The Chief Surgeon also had control of examination and re-examination of all new and old employees. He managed and supervised all hospital employees as well as the many local surgeons around the state who were under contract to the railroad to take care of employees locally from Jacksonville to Key West. All employees were hospitalized in St. Augustine except those whose condition did not justify the train trip to the city. The employees were treated at times by the contract local surgeons in the hospital in their community and the services for both doctor and hospital were paid for by the Association.

The Hospital had a training school for nurses and about ten students entered each year. Although it was a small hospital, the nurses who graduated were first rate. The first group I selected finished their state board examinations standing first among all hospitals in Florida. As part of their training, the nurses were

sent for a period of about six months to the Philadelphia Women's Hospital and the Florida East Coast Railroad paid their tuition. The doctors and nurses there were very complimentary regarding the work our student nurses did. The nursing program was already in effect when I came to the hospital in 1930 and it continued for a few years after that. It was discontinued because the state qualifications called for an increased length of training in other hospitals, which soon became financially prohibited. We were very proud of the caliber of nurses who entered our program and of those who graduated. They had a tremendous attitude toward the care of patients and I have always felt that this is one of the reasons that the East Coast Hospital was so popular. The hospital was an old wooden building on a noisy street and I felt when I took over that in order for us to compete with other hospitals, we had to have excellent nursing care as well as comfortable beds and good food. This we were able to provide.

Predecessors • My predecessors at the East Coast Hospital had been a Dr. James Worley, who was assisted by his sons Sam and Gaines. Dr. Worley was followed by Dr. Murray Seegars who stayed in St. Augustine during the winter season where he was also the physician to the Ponce de Leon Hotel and all of Mr. Flagler's hotels. During the summer he had a hotel practice in Saratoga Springs, New York. He died of a ruptured peptic ulcer sometime around 1923. He was followed by Dr. James Fogarty who was also mayor of St. Augustine. Dr. Fogarty left St. Augustine in 1926, moving to Daytona Beach. He was followed by Dr. William N. Parkinson, who became the Chief Surgeon around 1926. He was in partnership with Dr. W. Emory Burnett. Dr. Parkinson left St. Augustine in 1929 when he became a professor of clinical surgery and dean of the School of Medicine at Temple University in Philadelphia. Dr. Burnett followed Dr. Parkinson to Philadelphia where he served as professor of clinical surgery and later professor and chairman of the Department of Surgery for several years. These were the men who were connected with the East Coast Hospital before I came in 1930. I came from Mansfield, Ohio, where I had been Chief Surgeon of the Empire Steel Corporation. I remained as Chief Surgeon until October 1, 1963 when the Hospital Association was discontinued.

Hard times • During the early days we had some hard times and the railroad was placed in receivorship around 1934. It had entered a program of building with double tracking and an expansion of facilities. This occurred as a result of the Florida Land Boom in 1925 and 1926 and with the "busting" of this false prosperity and the failures that occurred in the early years of depression, the railway was unable to show a profit and pay its debts. Receivership resulted. William R. Kenan, who was Henry Flagler's brother-in-law, continued as one of the receivers and Senator Scott Loftin, head of the railway's law department, was the other one. During the early years it was hard to get funds to make changes in buildings and for equipment, although we were furnished with good surgical equipment as much of it was brought by the surgeons who used it.

Patients and practice • In the early days, a patient found it much more convenient to travel by train over long distances to obtain hospital and medical care than to come over poor sandy roads by automobile. It was remarkable that patients would travel long distances just to make an office visit. For example, we saw patients from Miami, Fort Pierce, New Smyrna Beach, Daytona and Jacksonville. The trains were convenient. Patients came on passes and transportation did not cost them anything. After the Hospital Association was discontinued in 1963 many of the patients continued to come to my office in St. Augustine from cities up and down the east coast just to make office calls. During the years I was in practice I had a secretary who was with me for 36 years and an office nurse for more than 36 years. They became familiar with patients up and down the state and often we would arrange one day to see patients from Miami and another day to see patients from New Smyrna Beach, etc. It was quite strange, looking back on it, to have two or three automobiles coming up with patients from small towns along the east coast to make office visits. This situation continued after I left the Hospital Association until I retired in 1963. I had many patients in the latter days of my practice who were children of patients I had in my early days of practice.

For their monthly contribution, the employees and their family were provided full medical and hospital care, also all their drugs originally. Later on when there were more specialized operations such as hip replacements and neurosurgical procedures the employees would be given an additional few hundred dollars. Some limit eventually had to be made regarding prescriptions when drugs became so expensive. For example, while we do not think of it at the present time, cortisone was a very expensive drug when it first came out and was almost prohibitive because of the cost.

Of course, antibiotics also were very expensive, so there were some limits on the cost of prescriptions after the antibiotic era began in the 1940s.

The only medical specialists we had were eye, ear, nose and throat, and pediatrics. Patients often were referred for consultation, usually to Jacksonville, but sometimes to Orlando and other areas. We had a very good urologist in Orlando who used to treat prostates with radium. The employees knew about him and many wanted to go there. We referred them for prostatic surgery, although for a period of time the urological surgeon would come to St. Augustine to do

prostatic work. If it was kidney surgery, I took care of that myself. It if was chest surgery, then the patient was referred, as I did only simple chest work. Once in a while I might get into a depressed fracture of the skull or, perhaps, an object penetrated the skull or may have to operate on a subdural or that sort of thing. In 1930, there was a general surgeon who was doing quite a bit of neurosurgery in Jacksonville. I cannot remember his name at the present time. When James G. Lyerly Sr. came down from Richmond Medical College and established himself in neurosurgery, most of these patients were referred there.

The East Coast Hospital also accepted private patients and, as a matter of fact, the bulk of my income came from their care. There was a two-tiered pricing system in effect at the hospital, one for hospital employees and their family and the other for private patients. To the best of my memory, a private patient in 1930 paid $5 for a ward bed, which included nursing care, meals, all drugs, all laboratory and x-rays. This same service was given to railroad families for $3. A private room for a private patient was $8 and for a railroad family $5. Operating room charge for a major operation was $10 for a private patient and $5 for a railroad employee. A minor operation room charge was $5 for private and $3 for an employee. For OB cases, delivery operating charges were $10 private and $5 for a railroad employee. The doctor's charge for anesthesia for a major operation was $10 private and $5 for a railroad employee, while the anesthetist charged $5 for a private patient and $3 for a railroad employee. Later on a charge of $5 was made to cover all drugs to private patients and $3 for a railroad family. Laboratory fees including x-rays were $5 for a private patient and $3 for a railroad employee. Additional charges were added during the hospital stay, but the cost to patients remained relatively modest.

An office call in the early 1930s was $2, a house call $3, a night call $5, and a hotel call $5. At that time there were many hotels in the St. Augustine area. Charges for major operations were $75 to $150 and minor operations from $10 to $25. The charge for delivering babies was $35 to $50. In those depression years a doctor probably got paid by about one third of the patients and in regard to a house call it probably did not even come to one third. Of course many patients figured it out and would not come to the doctor's office and wait, but had him come to the home and many times the doctor would not get paid anyway. That was the practice of medicine in those days.

At the time of large railway employment, which was the double tracking going on in the late 1920s and early 1930s, the bed capacity of East Coast Hospital was 112. Most of the time we had about 85 beds available. We eventually brought the capacity down to 55 beds and five bassinets as we discontinued the third floor in an effort to cut expenses in the 1930s.

Surgery • As far as the types of surgery, I did many different procedures. Most of it was general, such as abdominal, but I also did kidney surgery including nephrectomies. I also did surgery on cancers of the bladder. At that time we used quite a bit of radium, and I was able to obtain a grant from the Hospitals Radium Foundation in New York, under the direction of a Dr. Survy who was conducting research there. At that time we could use radium without charge and we did for cancer of the cervix, for example. We also used it for cancer of the bladder and planted radium seeds. Of course, during those days we did some radical breast, neck, and parotid gland surgery. We did very little vascular surgery, as radiographic imaging was not anything like it is at present. Radiographic imaging, which really was able to facilitate vascular surgery, did not come along until the 1950s and 1960s.

I thought we were well equipped. For example, when I came to St. Augustine in 1930 there were only four deep therapy x-ray machines in the state. One was in Miami, one in Tampa, one in Jacksonville and the other in East Coast Hospital, so we were among one of four hospitals that had this modality. Of course, many surgeries today would be done by specialists but in the 1930s and 40s general surgeons did most gynecological surgery. I did numerous radical hysterectomies. In those days there were tremendous fibroid tumors that would seem to fill up the whole abdomen and present a very difficult technical problem in removal. For example, you might have to split the fibroid down the middle, open it up and go in and get the uterine arteries and other technical aspects. I wonder how many gynecological surgeons today would do any better than we were with that type of case, which required special handling.

We also treated pediatric patients in the hospitals, things like pyloric stenosis. I did some cleft lips and palates but no chest work other than chest tubes in emergencies. Of course, back in the days of pre-antibiotics we had lots of empyema which we would drain and do rib resections. We also did gastrectomies for malignancies. I saw many tuberculosis patients but in those days they were sent to Orlando for special treatments in the sanitarium. We did radical neck resections for cancers and many thyroidectomies.

People today do not realize what thyroidectomies were before iodine and other medicines. Patients with huge goiters were very toxic. You had to get in very quickly to ligate the appropriate arteries and wait for them to quiet down, then go ahead with the thyroidectomy. My cousin, Dr. Wayne Babcock in Philadelphia, used to inject boiling water into the gland to reduce the toxicity and kill some of the tissue. Of course when iodine became available we would treat patients preliminarily with this, then go ahead with a thyroidectomy. Later we had other medicines to quiet toxic thyroids down and it was much easier, thyroid surgery was relatively easier. Prior to World War II most surgical patients were not intubated and it was not until after the war that intubation became

relatively common. I never saw a patient intubated for surgery until after World War II as I remember. I remember we got an anesthetist who had been to the Cleveland Clinic and she was the first one to intubate patients. She was here during the war.

The hospital had its own laboratory and did many things that are now a much more specialized service. We did not have centralized blood banking and some of the most sophisticated blood banking techniques were unknown.

We delivered hundreds of babies at East Coast Hospital. I remember doing a lot of deliveries in homes and made many house calls, sometimes of great distance.

I remember attending a gentleman from Hammond which is near Crescent City. He had pyonephrosis, but there was no hospital in Putnam County at that time, except a private hospital, and he came to me for help. He had a kidney full of stones, but we could not get him into any hospital because the man was essentially destitute. To take care of this patient I took another physician with me, Dr. R.D. Harris, to give the anesthetic, my operating room nurse, Mrs. Helen Baker, and a scrub nurse. We went over to Hammond and I operated on the patient on his kitchen table. We spent more time getting the flies out of the kitchen than we did on the operation, but the stones were removed and a drain was left in for drainage. I remember getting up at 4 o'clock in the morning and driving over there to care for the patient, about 70 miles, and back in time to go to work. I think this was in the early 1930s.

I am proud to say that East Coast Hospital is one of the first to use stainless steel wire in surgical operations and in more than 6,000 cases. I am not certain how many surgical cases I did but there must have been thousands of them in the 65 years I practiced medicine.

In all my years of practice I had two cases of malpractice and in both the insurance company asked if they could settle. They did, each one for $150. The total cost to my insurance company for coverage in the years I practiced was $300. There probably were other times that I should have been sued.

There were other physicians who spent a great deal of time working for the hospital, such as Dr. Gordon Fletcher, who had been a fellow intern with me at the University of Pennsylvania Medical School. He spent several years with Dr. Graham Mitchell in the pediatric department and worked in a childrens hospital in Cincinnati. There was also another fine physician by the name of Dr. Adam Walkup, who was very remarkable and took care of most internal medicine cases. He had additional training in cardiology and probably did more work without charge than any other physician in St. Augustine. Dr. Fletcher subsequently left Florida, moved to California and got into the management of properties for his family. Dr. Walkup continued practice in St. Augustine until he was quite old and had to quit finally on account of failing eyesight. When I came here in 1930, I found the physicians in Florida to be the finest kind of practitioners. They appeared unconcerned about whether they were paid or not and continued to render service regardless of the circumstances. They did not turn people away and wanted to contribute to society as a whole. They were not as good as physicians of today in the scientific and technical sense, they were not as well trained, but they had the interest of the patients at heart. I was particularly impressed with the character of the medical profession in the state of Florida.

Regarding the practice of surgery 50 years ago and today, there are obviously great differences. However, I do not believe we will ever again see the excellent all around surgeons that we had in the 1920s and 1930s. In those days we had few specialists, and I speak particularly of the professors we had in medical school. They did brain, spinal cord, urological, abdominal, chest, thyroid, and orthopedic surgery. With specialization these men confined their endeavors to one field and they were able to do it more capably. No one can realize in the pre-antiobiotic days how difficult it was in regard to surgical infection. Anesthesia was very difficult at that time. When patients were given ether they often got nauseated. The intravenous fluids of today did not exist and often if you gave patients a salt solution chills and fevers were apt to develop from the rubber tubing. It was often difficult to put patients under good anesthesia and get the relaxation necessary for surgery. Chloroform was helpful but dangerous. I used to use a great deal of spinal anesthesia. These patients did very well and looked much better afterwards than those under general anesthesia and were not so dehydrated. I used local anesthesia for hernia operations and for some appendectomies.

Things began to change ● The Florida East Coast Railroad provided a tremendous experience in my life and one which I will always cherish. In the 1950s things began to change somewhat. In 1957 nonoperating railway employees were awarded a fringe benefit payment of $6.80 a month for hospital and medical insurance. By nonoperating employees is meant those not concerned with direct operation of trains such as locomotive engineers, firemen, and conductors. The operating employees contributed a like amount voluntarily. When this change became effective, the railroad turned control of the Hospital Association over to labor unions, giving them the buildings and equipment for $1 a year. The Board of Directors then became composed of the 23 general chairmen operating the labor unions. Shortly after this change in regard to direction, the hospital employees were unionized. The duties of the Chief Surgeon, which was me, were so heavy and the management of labor relations so involved that a hospital ad-



The Florida East Coast Railway Hospital 1906.

ministrator was employed. I remained as Chief Surgeon for the Florida East Coast Railway and continued with examination and re-examination of employees, management of employees' injuries and particularly settlement of claims and litigation as a result of injuries. At the same time I was employed by directors of the East Coast Hospital Association as Chief Surgeon. I was paid a salary, but my principal income continued to come from the private practice of medicine and surgery. I also practiced general medicine because at that time almost all surgeons in the state accepted medical patients in addition to surgical patients. We continued the practice of employing local physicians to take care of Florida East Coast Railroad employees for a prescribed fee. If the local physicians felt that patients needed hospitalization, they were transported by train to St. Augustine if this could be safely achieved. If not, they were treated in a local hospital at the expense of the Hospital Association.

This was pretty much the situation until 1963 when employees of the railroad went on strike. At this time, Ed Ball had taken over control. The number of employees were greatly reduced and there was a marked increase in litigation regarding personal injuries. These were employees who were suing the railroad company as a result of injuries on the job. This litigation often required physicians to spend several days in Miami where most cases were tried. The railway never asked me to favor it in testimony. I think employees trusted me to give an honest report regarding their degree of injury. The railway continued to pay the contribution for accepted employees who were not labor union, at that time about 550. Toward the end of 1963 I received a letter stating that the railroad would discontinue these contributions and I knew then that the Hospital Association would end. My letter of resignation as Chief Surgeon of the railway and a letter from the railway announcing the abolishing of the office of Chief Surgeon crossed in the mail.

The Florida East Coast Railroad Hospital ceased operations in 1963. I continued to practice medicine and surgery at the Flagler Hospital in St. Augustine until July 1, 1983. I had finished 64 years in the study and the practice of medicine. The Florida East Coast Hospital was torn down and today the site is a vacant lot. The Florida East Coast Railway is no longer involved in the field of direct medical care for its employees.

I have described the operation of the Florida East Coast Railroad in my many years of medical practice so that those physicians in the state who never knew this existed might be informed of a brief period in the history of medicine and this would be recorded for reading and future reference.

Acknowledgment

Much credit for the successful operation of the East Coast Railway Hospital is due the following physicians and surgeons, all capable practitioners and who served valiantly in the Army during World War II: Hardgrove S. Norris, Joseph A. Shelley, Raymond S. Cafaro and Reddin Britt. Doctors Charles C. Grace and William J. Gibson were skilled EENT specialists upon whom we depended. Dr. Donald T. Rankin was our radiologist.

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Camp Miami, 1898

William M. Straight, M.D.

In the summer of 1898, Miami was a quiet little city nestled on the north bank of the Miami River at its entrance to Biscayne Bay. Its residents were largely young men and women, enthusiastic, energetic and imbued with the prospect of building a great city. The community's health seems to have been good; no death had been recorded since February 1898.[1] C. Arthur Williams, correspondent for the *Houston Post*, left this lyrical description (Fig. 1):

> "In the immediate vicinity of the Royal Palm Hotel, where the beautiful Miami River joins its limpid waters with those of Biscayne Bay, where tropical trees, lovely as a painted picture, stir softly over lawns of velvet green, in response to the caresses of the languorous Southern breeze, where the white-winged boats go out across the bay, between the keys, into the broad Atlantic beyond, where every live thing seems happy and glad, where in short, 'every prospect pleases only man is vile'—there is beauty indeed, and of a kind which would warm the heart of the painter and intoxicate the senses of the lover of the artistic in art and nature."[2]

Miami at that time had 2,000 residents and thus the right to call itself a city.[3] It boasted of three miles of paved[4] streets, an embryonic sewerage system of one and three-quarters miles of pipe with an outfall in the Miami River at the foot of Avenue D (today's Miami Avenue), and a municipal water system which supplied "an inexhaustible-supply of the purest water. (Fig. 2)"[5]



This inexhaustible supply of the purest water was obtained from a "spring in the Everglades" (Fig. 3).[6] A half-inch thick steel pipe, 12 inches in diameter, was laid underground to bring the water four miles to the city standpipe. The standpipe, 120 feet high and 20 feet in diameter, was located on Avenue F (today's S.W. 1st Court) just north of the Florida East Coast Railway (F.E.C.) freight station. A kerosene driven pump sucked the water from the spring and into the standpipe where it fed by gravity flow through the city water mains.[7] Miami boosters claimed this water system was sufficient to supply a city of 25,000.

Other features of the City of Miami in the summer of 1898 were fire mains in the business district, sidewalks on Twelfth Street (today's Flagler Street), 23 brick and two concrete business buildings, and four hotels: Royal Palm Hotel, Miami Hotel, Hotel Biscayne and Hotel Conolly. There were six church organizations. At about today's N.E. Seventh Street and Biscayne Boulevard, there was the F.E.C. passenger terminal and dock which permitted connection with ocean-going vessels of less than 12-foot draft. The citizens of Miami and the surrounding communities were served by six physicians[8] and three dentists.[9] Make no mistake, Miami was no hick town and the citizens were fiercely proud of what they had accomplished in the two years since the city's incorpora-

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Fig. 1.—First Division on parade, Royal Palm Hotel Grounds, 1898. (Courtesy Florida State Archives)

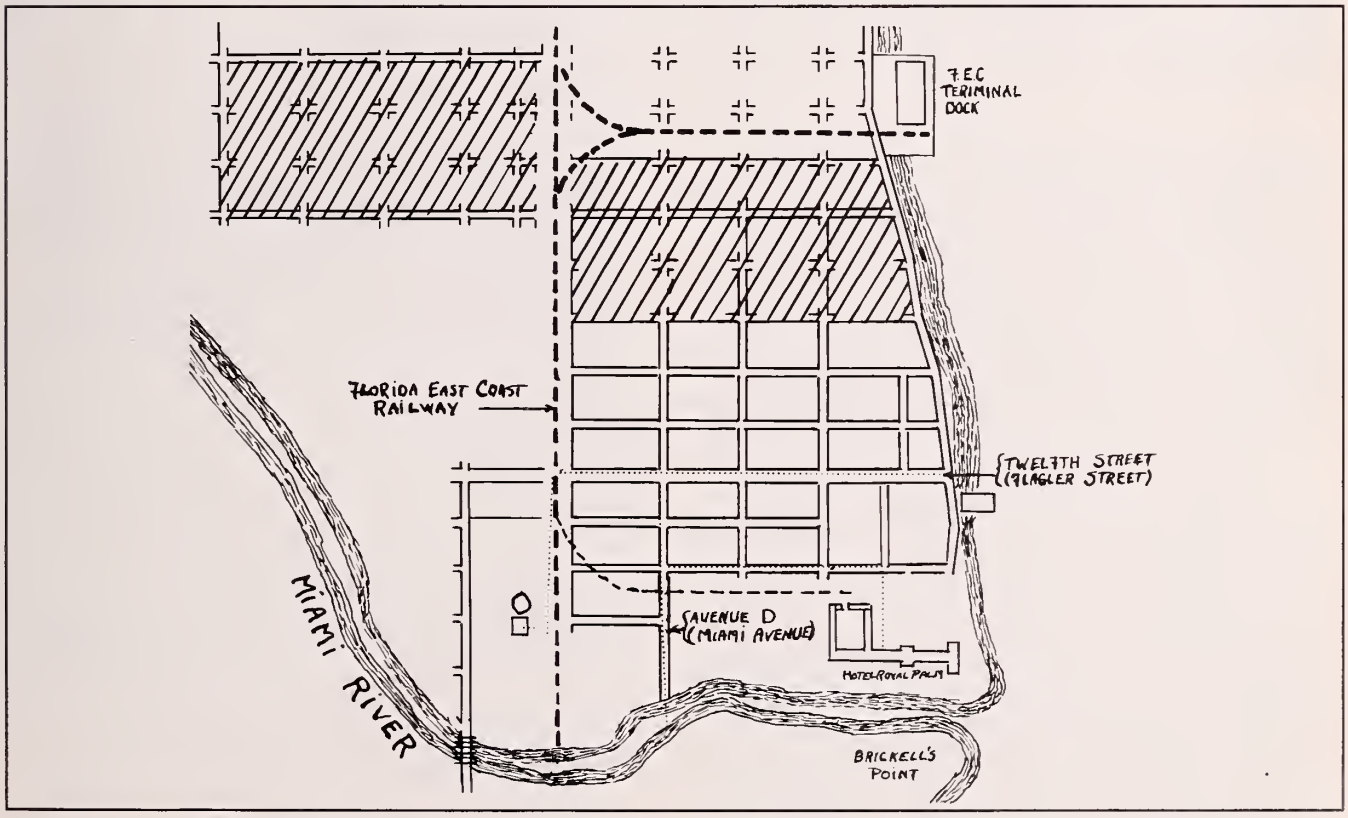


Fig. 2.—Miami, Summer, 1898. Modified from map of the City of Miami, 1905. (Shaded area indicates the campsite)

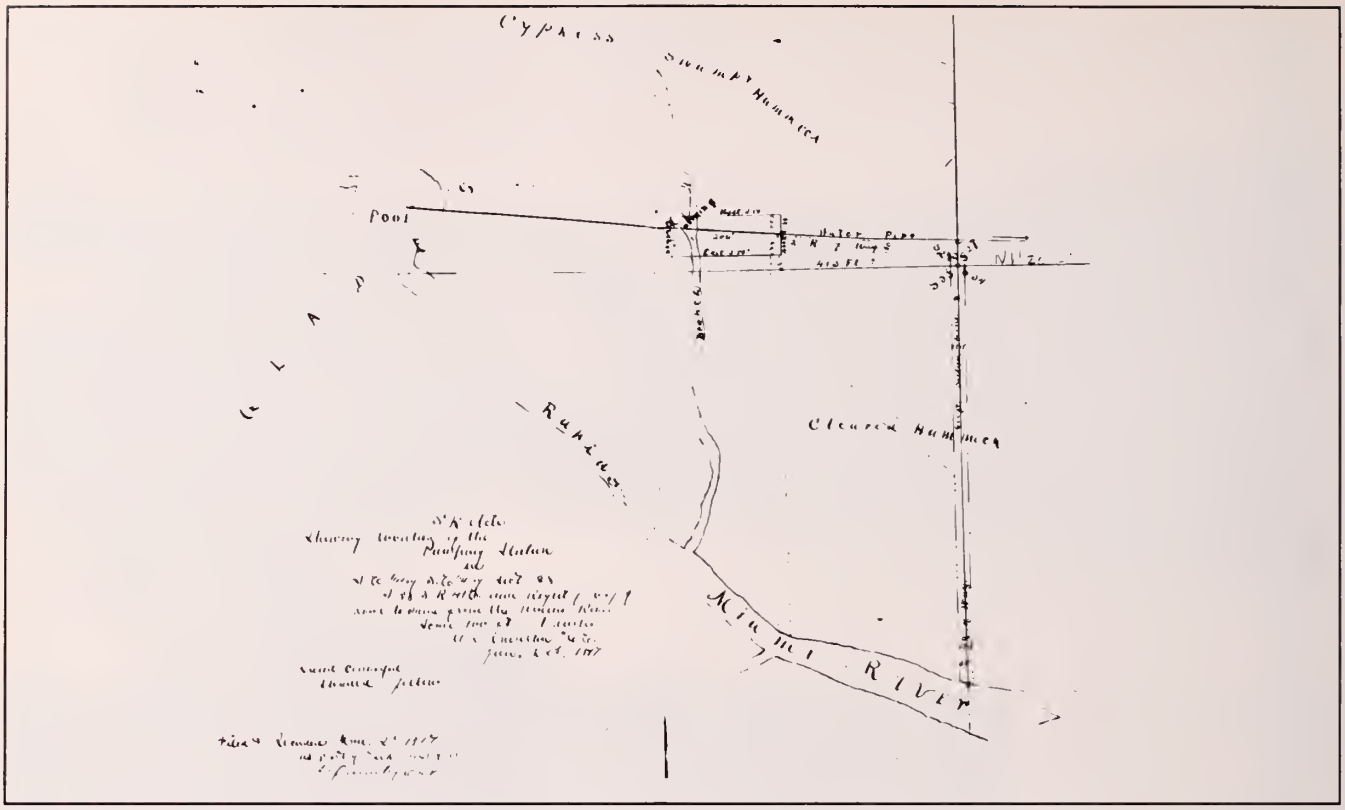


Fig. 3.—Source of Miami's water, 1898. (Courtesy of Historical Museum of Southern Florida, Miami)

tion. Then came the Spanish-American War and the city of 2,000 within a week's time became host to 7,500 U.S. Army Volunteers (the First Division, Seventh Army Corps). They remained a little more than seven weeks[10] but they made their mark on the infant Miami.

Last of troop trains • With the screeching of steel wheels on steel rails and the shuddering of the coaches as the couplings thudded together, the last of the troops trains arrived in Miami, June 30, 1898. For W.E. Rollins, Co. G., 2nd Alabama Volunteer Infantry, it did not happen a moment too soon. Sick with fever of 104° when he entrained at Spring Hill, Alabama, he had spent three miserable days and nights in the open coach stifled by the summer's heat and choked by smoke from the wood burning engine as the train chugged along at 15 miles per hour.[11]

Even before the wheels had stopped, Rollins' buddies were on their feet, shouldering knapsacks and rifles, eager to get off the coach. One of them picked up his gear and another walked alongside him as the unit marched to their campsite along today's N.W. Fifth Street at about N.W. Fourth Avenue. The campsite was an expanse of pine and palmetto thicket (Fig. 4), uncleared and without water supply or sanitation facilities. While Rollins and 89 others on the sick list were bedded down, the more able soldiers hacked a suitable campground from the virgin thicket. For the first several days Rollins seemed to improve but then



Fig. 4.—The campsite was pine and palmetto thicket. (Koenigsberg: Southern Martyrs[2])

the fever returned with a vengeance. Major S.S. Pugh, Surgeon of the 2nd Alabama Volunteers, made a diagnosis of typhoid fever and transferred him to the division hospital. There he made little improvement; the fever recurred daily and he became weaker and more emaciated. In August he was transferred to the first division hospital in Jacksonville where he died on August 19th.

Rollins' case was not a singular one at Camp Miami. There was sickness in each of the regiments before and upon arrival. During the first week or so the amount of sickness seemed to decrease but then the sick list took a sharp upturn. By the middle of July when Lieutenant Colonel L.M. Maus, Chief Surgeon of the Seventh Army Corps, visited Miami, he "found the hospital with nearly 400 cases in it from these six regiments, many of them fevers which the hospital doctors diagnosed as 'continued malarial fevers.' Moreover there were 900 to 1,000 men in these regiments sick in quarters, and there were a great many suffering with diarrhea and dysentery."[12]

Diagnoses and therapy • The most common symptoms encountered by the surgeons at Camp Miami were fever, myalgia and malaise. The most common diagnoses made by the medical officers were intermittent or remittent malaria. Malaria was a popular diagnosis among southern physicians for any case of fever; it was a traditional disease of the south. Malaria was associated with swampy country and the vast swamp known as the Everglades was a mere four miles west of Miami. Major Pugh, regimental medical officer of the unit camped furtherest west,[13] explained the prevalence of fever in his unit thus:

> "Close by straggled the Miami River with its wide, marshy banks that were flooded and freed with the rise and fall of the tide. The water, semi-brackish, was of a character idealic for the abode of malaria."[14]

Major Pugh listed 136 cases of malaria in his regiment during the month of July 1898. Several weeks later when the soldiers were transferred to Jacksonville, blood smears were done on many of them but malaria parasites were not found.[15] The Reed Commission, after an intensive investigation, concluded that malaria was rare in soldiers who had not been out of the United States.

Malaria or not the presence of fever (clinical thermometers were plentiful in Camp Miami) was a clear indication for the use of quinine. One surgeon described his method of giving quinine:

> "To every case that came into the hospital I gave two grains of quinine three times a day on the theory of Southern physicians that you can't cure anything in Florida, as I have heard them say, without quinine."[16]

Next to the malarias the most common diagnoses were diarrhea and dysentery. These were blamed on the drinking water, bad food, poor preparation of food, drinks or food bought from the vendors that ringed the camp or liquor obtained from bars just beyond Miami's city limits.[17] The Reed Commission concluded that many of the cases diagnosed as diarrhea or dysentery were in fact typhoid.

The therapy of diarrhea and dysentery at that time included boiled milk. At one point it was charged that the supply of milk was insufficient to meet the needs of the dysentery patients. Other items used for diarrhea and dysentery were castor oil, rectal irrigations with silver nitrate, ipecac and morphine. In the more severe cases nothing seemed of benefit and at least three soldiers died with a diagnosis of dysentery at Camp Miami.

Measles was epidemic; two deaths from measles are noted. Mumps, pneumonia, bronchitis, pleurisy, alcoholic gastritis, gonorrheal phimosis, asthma, lumbago, epilepsy, facial neuralgia, appendicitis, erysipelas, lymphangitis, syphilitic rheumatism, gonorrheal rheumatism and Bright's disease are other diagnoses appearing on the First Division Hospital Register at Camp Miami.

Hepatitis was probably a frequent disease in the camp although it was not always recognized. It appears on the sick list as catarrhal jaundice, obstructive catarrhal jaundice and malarial jaundice. Using today's terminology most of these would be cases of type A or possibly non-A, non-B hepatitis. This may have come to Miami with the troops from Alabama for the medical officers of both Alabama regiments believed jaundice to be the most prevalent disease in their units. Four cases appear in the division hospital register during July 1898 and 14 during August after the move to Jacksonville.

Far and away the most serious and the most frequently fatal disease at Camp Miami was typhoid fever. Typhoid had been recognized in each of the six regiments prior to their arrival. The 2nd Alabama Volunteers had experienced six deaths from this disease while still encamped near Mobile. Indeed, the first case of typhoid was admitted to the Camp Miami division hospital on June 26th, barely 48 hours after the first troops arrived at Miami. Thus it is clear that the troops brought typhoid with them.

Both the regimental and hospital surgeons were slow to arrive at a diagnosis of typhoid. This was true not only at Miami but at all the camps in 1898. Following a careful investigation the Reed Commission concluded that, "Army surgeons correctly diagnosed about half of the cases of typhoid fever."[18] Apparently the medical officers at Camp Miami were even more reluctant than most to make this diagnosis. A special investigative board was convened at the division hospital on July 20th:

> "After making one post-mortem examination

Table 1.—Number of Cases of Typhoid in First Division from Enlistment to Mid-September, 1898.

	1st Tex.	1st La.	1st Ala.	2nd Tex.	2nd La.	2nd Ala.	TOTALS
Probable Typhoid	111	31+	158	186	177	158	821+
Diagnosed Typhoid	50	31	19	23	22	31	176
Prior to arrival in Miami	5	3	30	1?	2	18+	59+
At Miami Probable Number	—	2+	35	4+	27	—	68+
Deaths from: Diag. as Typhoid	8	7	7	4	8	1	35
Probable	8	11	10	8	8	8	53
Deaths at Miami From	0	2	3	4	3	1	13

KEY:
— means no data available
+ means more than
? means uncertain
(Modified after Reed Commission Report)

and having a large number of samples of blood submitted to the Widal test, they concluded, July 20, that there were 50 instead of only 8 cases of typhoid fever in the division hospital.''[19]

It is not possible to arrive at valid statistics about the incidence of typhoid at Camp Miami. The Reed Commission concluded from study of camps throughout the United States that about one fifth of the soldiers contracted typhoid and of these about 7.61% died.[20] If we apply these percentages to the 7,500 men at Camp Miami, there would have been 1,500 cases of typhoid with 114 deaths. Such was not the case. By pooling the data of three sources[21] the total would be 24 soldier deaths of medical diseases during the seven weeks at Miami. Fourteen of these were listed as from typhoid and six more as fever of undetermined origin or dysentery which may have been cases of typhoid. The Reed Commission reported 53 deaths from typhoid in the First Division but the statistics cover the experience of the division while encamped at Mobile, Miami and Jacksonville (Table 1.)

Causes of disaster • Why did such a disaster occur? Various explanations have been offered. Perhaps the hard labor in the hot sun clearing the camp grounds and marching on the drill field broke the men's resistance. Perhaps the lack of rest occasioned by the swarms of flies and mosquitoes was a factor. Some blamed inadequate or poorly prepared food and/or an infected water supply. There were complaints about the poor location of the division hospital and of inadequate medical and/or nursing care. But the real culprit was likely the abdominable human waste disposal arrangements.

When the troops arrived the area allotted for their campsite was a largely uncleared pine and palmetto thicket. On the accompanying map (Fig. 2) the shaded area indicates the campsite as described by John Sewell who was in charge of clearing the land, drilling surface wells and paving roads.[22] According to Sewell the campsite east of the F.E.C. mainline extended to the bay and was bounded on the north by the present day N.E.-N.W. Sixth Street and on the south by today's N.E.-N.W. Third Street. West of the railroad the camp extended to the present day N.W. Sixth Avenue and was bounded on the north by today's N.W. Eighth Street and on the south by today's N.W. Fifth Street.[23]

The original plan is said to have been to extend the campsite north along the bayfront so that all units would have easy access to the bayfront. For unclear reasons this was not done and only the first regiments to arrive were encamped near the bay. This led to problems that had much to do with the sickness and death.

Henry Flagler had agreed to clear the campsite and provide a water supply and sewage disposal system at his own expense. However, when the troops began



Fig. 5.—Soldier in full dress, 1898. (Courtesy Historical Museum of Southern Florida, Miami)

arriving at the rate of 1,000 men each day, only the bayfront site had been cleared and supplied with surface wells. Thus most of the troops had to spend their first ten days clearing land on which to pitch their tents. Angered at having to do hard labor in the broiling sun when they had enlisted for the thrill of battle, they dubbed themselves "The Flagler Improvement Company."[24] On the night before their departure seven weeks later, they jubilantly sang, "We'll hang old Flagler to a sour apple tree," until they were too hoarse to utter a sound.[25]

Another source of complaint was the enervating two mile march to the drill field along a dusty wagon road that parched the mens' throats and seared their lungs, and the hours of drilling in the hot sun on the rock studded field.[26] Initally maneuvers at the field were carried out from eight in the morning until one in the afternoon However, the soldiers, dressed in woolen uniforms (Fig. 5) (the issue of duck uniforms came too late for the troops at Camp Miami), fell out with heat stroke in such numbers that on July 29th, the drill hours were changed to four a.m. to nine a.m. and four p.m. to five p.m. and the men were restricted to camp from 11 a.m. to three p.m.

Mosquitoes and sandfleas were a problem for the soldiers but were not indicted as carriers of disease. This is suggestive evidence that the medical officers who so frequently diagnosed malaria thought of it as a disease caused by a miasma arising from swamps rather than a disease transmitted by mosquitoes.[27] Apparently the mosquitoes were scarce until the middle of July when they descended upon the camp in swarms. One soldier writing home said the mosquitoes were so thick "we even hang our hats on them at night." Mosquito nets were bought for the hospital and the convalescent ward but were not available to most of the soldiers. Even though the nets gave respite from the fiendish little pests, many of the sick pushed the nets aside for they also shut out what little breeze was stirring. Sandfleas were not impeded by the mosquito bars but they were bad only around dusk and did not destroy sleep. In the camp smudge fires were used to drive off mosquitoes but the smoke produced respiratory irritation and made sleep difficult.

During the first ten days the troops were in Miami, food was a problem. Lieutenant General O.E. Wood, Chief Commissary Officer of the Seventh Army Corps, reported following a trip to Miami on July 13th, "that they had been receiving fresh meat very irregularly and very few fresh vegetables."[28] He gave the appropriate orders and thereafter the camp received 10,000 pounds of fresh beef daily furnished by Swift and Company. The only other complaint about the food seems to have been the shortage of fresh milk mentioned previously.

A source of vociferous complaints from the wife of the general in command of the second brigade was the division hospital, its location and the care given there. According to Blackman[29] the hospital was located on Avenue C along Thirteenth Street (today's S.E. First Street at S.E. First Avenue). Others mention it as being "in the center of town and closed in by dwellings, hotels and boarding houses."[30] It is said to have been near a hole 30 feet in diameter and six feet deep that was used for trash deposit and contained water covered by green scum. Several observers thought the hospital was located in a very unhealthy spot but the division's chief surgeon, Major Appel, thought it ideally located.

The division hospital is described as a tent hospital:[31]

> "The division hospitals of the Seventh Army Corps, at Jacksonville and Miami, Florida, consisted of 6 tent pavillion wards of 5 tents each, with a fly between the second and third tents of each ward. The pavillions formed a semicircle of radii from a central point, at which was established the office, dispensary, etc., of the hospital. Two pavillions were to be regarded as the allowance of accommodation for each brigade under ordinary conditions; and the attempt was made to keep men of the same regiment together to satisfy the desire of the volunteer troops to preserve regimental organiza-

tion in the medical service of the corps. The prevalence of measles and mumps necessitated the pitching of extensive isolation wards in connection with the formally planned pavillions."

The hospital tent of that day was 14 feet long, 15 feet wide, and 11 feet to the ridge, the wall being 4½ feet high. Each tent accommodated six hospital field cots, three being placed with the heads against each lateral wall, leaving a center aisle or passageway from end to end.[32]

In addition to the tent hospital there was a building assigned to the division hospital as a storehouse. There also seems to have been a building (site not identified) that at one point served as an isolation ward for typhoid cases.[33]

Finally, there was a convalescent ward organized and administered by Eleanor Kinzie Gordon, wife of the general commanding the second brigade. This was housed in "a large open building, 40 × 100 feet, to the rear of the (Royal Palm Hotel) Casino." When the bulk of the troops were transferred to Jacksonville, this building housed some of the 150 patients who were too ill to travel.[34]

Major Daniel M. Appel was the chief surgeon of the First Division and thus the ranking medical officer at Camp Miami. Each of the six regiments had a surgeon and there were five medical officers attached to the hospital. Major W. N. Vilas was surgeon in charge of the division hospital and he was assisted by four Acting Assistant Surgeons. There were 31 regular army privates of the Hospital Corps who served as nurses and attendants; their number was augmented as needed by enlisted men detailed from day to day by the regimental commanders. Apparently there were no female nurses at Camp Miami; on one occasion Major Appel requested trained female nurses of the Red Cross representative but he promptly received a telegram from his superior, Lieutenant Colonel L.M. Maus, ordering him to cancel the request. The nurses worked 12 hour shifts with one assigned to each hospital tent for the day shift and one for the night shift.[35]

The division hospital was designed with a bed capacity of 200[36] but the inpatients often exceeded this number. At its peak load, August 2, 1898, there were 354 patients in the hospital.[37] There were accusations that patients were forced to lie on the ground without bedding. Major Appel denied this although he did admit that on occasion convalescent patients had to sleep on the wooden floors of unoccupied tents, but he stated they were supplied with proper bedding. Apparently the hospital was supplied with adequate equipment and sufficient medicines. On deposition before the Dodge Commission, Major Appel stated there was never a lack of quinine, morphine or strychnine. At times calomel was in short supply, "but then I bought it at the drug store (Townley Brothers Drug Store)."

The loudest and most frequent complaint of the troops was the unpalatable and "infected" drinking water. John Sewell, at the order and expense of Flagler put down nearly 50 surface wells (12 to 18 feet deep) capped with pitcher pumps. Initially these provided a palatable water supply but after about three weeks of occupation of the campsite, the onset of daily rains and a sharp upturn in cases of fever, these wells became suspect and their use was ordered discontinued except for washing purposes. Even before this order was given Flagler's men had laid pipes, with faucets at convenient intervals, on the surface of the ground and connected to city water supply. This supposedly brought pure Everglades water, the same as used at the Royal Palm Hotel, to the camp. However, the hot sun bearing down on the pipes made the water unpalatable and the troops preferred the cooler water from the surface wells. Furthermore, the city water was described as "about the color of the Missouri River and has a taste of vegetable matter that renders it unpleasant." An attempt was made at Flagler's expense to run the city water through barrels of ice and thus make it more palatable but this had little effect. Believing it infected and a factor in the rising sick list, specimens were sent to laboratories in New Orleans and Washington, D.C. No infection was found but the water was pronounced unfit to drink because of the taste and particulate matter. Orders were given to boil all water used for cooking or drinking and Flagler furnished barrels and heating units to accomplish this, however, the men disliked the taste of boiled water and there were insufficient vessels in which to cool and aerate the water. The men defied orders and continued to drink from the surface wells until the pump handles were finally removed. Despite the conviction of the soldiers and some of the medical officers that the water supply was a chief cause of disease, there was no objective evidence that this was the case.

Sewage disposal • Undoubtedly the major cause of the sickness and death at Camp Miami was inadequate sewage disposal. Initally it was planned that the regiments would be close enough to the bayfront to permit latrines connected to screened, galvanized iron lined, inclined wooden troughs which would be sluiced with water such that the sewage would be carried to outfalls in the bay. With reorientation of campsites as previously mentioned only two regiments were able to use the trough system. A third regiment used a combination of sinks and "floating privies." There is no description of the floating privies; possibly they were latrines on pilings or barges some distance offshore in the bay. The remaining three regiments, more than 3,600 men, were dependent upon sinks and the tub system. At first attempts were made to dig long trenches to serve as regimental sinks (latrines). Small charges of dynamite were used to penetrate the Miami limestone, but these could be dug only two or three feet whereupon they filled with water thus threaten-

ing the safety of the nearby surface wells. After about a week or two these latrines became so malodorous and unpleasant that they were no longer used.

As a final solution to the human waste disposal problem of the regiments back from the bayfront, the tub system was utilized. Galvanized iron tubs were clustered behind screens at convenient locations. Across the mouth of the tub a plank was laid to serve as a seat. After each use the soldier was to cover his droppings with lime or carbolic acid provided nearby. The tubs were to be carted twice each day to a large sluiceway on the bayfront (at about the level of today's N.E. Fifth Street) where it was to be dumped and carried by water flow to an outfall in the bay. This was a most imperfect system because the covering of the feces and the disinfecting and emptying of the tubs were not regularly done. Furthermore the contents of the tubs were spilled both at the latrine and along the route of transport and the latrines became fouled, odorous and the breeding place for swarms of flies. Often because they did not want to brave the flies and odors around the latrines or simply found the walk to the latrine inconvenient, soldiers took to the palmetto patches near their tents. One officer complained he could go no more than ten feet beyond the last row of tents without soiling his boots.

In 1898 it was known that typhoid bacilli were to be found in the stools and urine of typhoid patients. The presence of bacilli in excreta during the prodromal stage of typhoid and the possibility of infecting latrines before the disease became manifest were commented upon by the Reed Commission. It was also known that typhoid could be spread by contaminated milk or water but the Commission was unable to demonstrate such spread in any of the Florida camps. The Reed Commission concluded that the chief mode of typhoid transmission was from the fecal wastes either by flies or by the unhygienic practices of the men.

The Reed Commission investigators in the camp at Jacksonville tracked flies with flecks of lime on their feet from the nearby latrines to the food in the kitchen and mess halls. Also at this time, typhoid bacilli were cultured from the bodies of flies. In the camp at Jacksonville they observed men coming from the latrines to work in the kitchen, serve in the mess hall and feed themselves without washing their hands. They also noted that men detailed from the ranks to work in the hospitals often emptied bedpans of dysentery and typhoid patients without washing their hands between patients. Not known at the time was the presence of the typhoid baccilli in the stools of convalescent patients and the typhoid carrier state. Often convalescent patients were detailed to kitchen or mess hall duty until they were strong enough to return to full duty, thus promoting the spread of typhoid. The Reed Commissions concluded that the principal source of the typhoid epidemic in the camps in 1898 was "camp pollution," and that the greatest number of cases arose in those regiments dependent upon the tub system of human waste disposal. These conclusions were clearly valid for Camp Miami (Table 2.)

The departure • The war was winding down, Spain asked for peace terms which were dictated by President McKinley on July 30, and the clamor about the unhealthful conditions and sickness at Camp Miami became deafening; it was time to move. Between August 1st and August 12th the troops entrained for Camp Cuba Libre, Jacksonville. Left behind were approximately 150 patients who were unable to travel and another 60 able to travel who had been left behind for one reason or another. Also left behind were three acting hospital stewards, 40 privates of the Hospital Corps, and three medical officers: Captain F. J. Chalaron, Captain M. B. McGuire and Acting Assistant Surgeon W. H. Oates. As the sick improved they were sent by rail to Jacksonville. As the number became less the division hospital was dismantled and the remaining patients moved to the convalescent ward established by Eleanor Kinzie Gordon.[38] Finally, on the morning of September 2nd, the last of the patients, physicians and attendants entrained for Jacksonville. *The Miami Metropolis* of that date notes, "There have been 28 deaths from disease in the hospital and fatalities through accident, murder, and suicide in Miami among the troops."[39]

Impact on the community • Before closing this account let's look at the impact of the camp sickness upon the civilian community of Miami. The social impact upon the community has been covered in articles by other authors.[40]

As sickness mounted in the camp there was great concern in the business community that Miami would gain a reputation as an unhealthy spot. Each weekly issue of *The Miami Metropolis* seems to downplay the gravity of the situation. One finds headlines such as "Dr. Vilas Jubilant Over the Condition of the Sick," and comments such as, "as a rule, the troops. . .are well satisfied with their camp," and a quotation from an unnamed hospital employee, "The medicines act quickly and the air is invigorating, so there is rapid improvement in nearly every case." On July 22nd is the statement, "Each day more soldiers are discharged from the hospital than are sent to it." At best this had to be wishful thinking for the hospital load at that time was building toward its peak a few days later.

Not until July 29th, does the *Metropolis* admit all is not well. In an article on the front page noting that the troops may move in a week to ten days, it states, "There are quite a number of cases of sickness among the soldiers." The writer goes on to say the majority are cases of measles with some cases of typhoid, and that Miami is no way responsible for these. He then adds, "Our own citizens are enjoying the very best of health.

Table 2.—Condensed Sick Report, July 1898, 1st Division, U.S. Volunteer Infantry.

Disease	1st Tex.	1st La.	1st Ala.	2nd Tex.	2nd La.	2nd Ala.	TOTALS
Mean Strength	1,287	1,237	1,215	1,253	1,140	1,236	7,368
Diarrhea	245	47	22	87	46	34	481
Dysentery	9	31	30	31	22	31	154
Intermit-ent Malaria	92	152	187	278	25	108	842
Remittent Malaria	9	23	14	—	7	28	81
Other Diseases	546	228	208	222	65	103	1,372
Awaiting Diagnoses at end of month					74		74
Methods of Feces Disposal	Sinks & Floating Privies	Trough Sinks	Trough	Sinks & Tubs	Sinks & Tubs	Sinks & Tubs	



Fig. 6.—The troops left eagerly. (Picture courtesy of Mrs. John E. Junkin)

But were they? The *Metropolis* of July 29th notes, "John Townley, who has been sick with the measles is beginning to get out again." Following this is the note that several other townspeople had been down with the measles. On August 5th, it notes that Dr. P.T. Skaggs "is seriously ill with measles." On August 12th, a child and another adult are mentioned as seriously ill with the measles. On September 2nd, the *Metropolis* records the death of a 21-year-old man from measles. A review of the Interment Register of the City of Miami Cemetery reveals two civilian deaths that August, both adults, from measles. Thus it seems highly likely measles spread from the camp to the civilian community.

What about typhoid? It also seems to have spread to the civilian community. The Interment Register records four deaths among civilians during August and September; two of these were black adults. Colonel Maus is quoted by the Reed Commission as saying, ". . .the negro element there (Miami) used water from the wells, and there is a great deal of typhoid fever among the negroes."[12] Recall that the regiments of the second brigade were camped west of the railroad and adjacent to Miami's black town. This brigade was dependent upon the tub system for human waste disposal and had the highest incidence of recognized typhoid.

Still the editor of the *Metropolis* insisted, "Miami water does not produce typhoid fever among its own citizens." When all the information came in, it seems he was correct. Nevertheless, when the troops were gone, the editor exhorted the city fathers to insist that all driven wells be pulled up and that the use of open wells be prohibited, ". . .since the infection of the well water by the troops with typhoid germs."[42]

From the vantage point of nearly a century it seems obvious that the fledgling city of Miami was miserably unprepared to host the 7,500 soldiers who descended upon it in less than a week. Indeed, the United States was unprepared for the rapid mobilization of some 247,000 men in a matter of weeks. If more time had been available and more thought given there would almost certainly have been less sickness and fewer deaths, both military and civilian.

Despite the valiant efforts of the newspaper editor to minimize the calamitous medical problems that assailed Camp Miami, the word got out and Miami received less than favorable publicity. After about seven weeks the troops left eagerly and the townsfolk were not sad to see them go (Fig. 6).

Acknowledgments

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1. The Miami Metropolis, August 5, 1898, p. 8.
2. Koenigsberg, M., Southern Martyrs. A History of Alabama's White Regiments During the Spanish-American War, Touching Incidentally on the Experiences of the Entire First Division of the Seventh Army Corps. Montgomery, Alahama: Brown Printing Co., 1898, pp. 158-159. Hereinafter listed as: "Koenigsberg: South. Martyrs."
3. According to Florida law at that time a community of 300 or more registered voters was entitled to call itself a city.
4. Pavement consisted of crushed rock which had been rolled smooth and wetted down. This gave off an annoying glare and, in the dry season, clouds of dust. Sewell, John, John Sewell's Memoirs and History of Miami, Florida, privately printed, 1933, pp. 143-146.
5. Letter. Henry M. Flagler to Senator Platt, April 30, 1898.
6. A pond, possibly a boil from the Dade County Aquifer, just above the rapids of the Miami River—on today's map this would be located about one fifth of a mile west of N.W. 27th Avenue and about one hundred feet north of N.W. 20th Street, Figure 3.
7. On the map, Figure 2, the dotted line traces the course of both the sewer and water lines as they existed in 1898.
8. Doctors James M. Jackson Jr., S. Mills Fowler, John G. DuPuis, P.T. Skaggs, Eleanor Galt Simmons and John W. Jackson.
9. M.D.L. Dodson, R.E. Chafer and Gillespie Enloe.
10. The first troops arrived about midnight June 24th, the main body of the troops were gone by August 12th, and the last of the sick and their attendants left on September 2nd, 1898.
11. Koenigsberg: South. Martyrs., p. 166; The Miami Metropolis, June 24, 1898, p. 1.
12. Reed, Walter; Vaughan, Victor C., and Shakespeare, Edward O.: Report on the Origin and Spread of Typhoid Fever in United States Military Camps During the Spanish War of 1898. Two Volumes. Washington: Government Printing Office, 1904, Vol. 1, p. 507. Hereinafter cited as "Reed Commission."
13. This regiment was camped between today's N.W. Fifth Street and N.W. Eighth Street and possibly from N.W. Fourth Avenue to N.W. Sixth Avenue.
14. Koenigsberg: South. Martyrs., pp. 169-170.
15. The malaria parasite had been identified in the blood of patients in 1880 by Alphonse Lavaran. The author has found no evidence that blood smears for malaria parasites were done at Camp Miami.
16. Vickery, H.F.; Jackson, Henry; Minot, J.J., and Hewes, H.F.. Experiences at the Various Hospitals in the Diagnosis and Treatment of the Disease Prevalent in the Army, Boston Med. and Surgical Journal 139:561-567 (Dec. 1), 1898.
17. Several intestinal parasites were known at that time and Shiga had isolated the dysentary bacillus in 1897. There is no evidence that stool examinations were done at Camp Miami.
18. Reed Commission, p. 674.
19. Ibid, p. 519.
20. Ibid, p. 674.
21. The First Division Hospital Register; Koenigsberg: South. Martyrs and City of Miami Cemetery Interment Register.
22. There are at least two other descriptions of the campsite boundaries, The Miami Metropolis, July 1, 1898, p. 2; Blackman, Ethan V., Miami and Dade County, Florida. Its Settlement, Progress and Achievement. Washington: Victor Rainbolt, 1921, p. 43. Reprint by The Mickler House Publishers, September 1977, which differ in some details.
23. Sewell, John: John Sewell's Memoirs and History of Miami, Florida, privately printed, 1933, p. 150.
24. The Miami Metropolis, July 29, 1898, p. 4
25. Koenigsberg: South. Martyrs, p. 185.
26. The drill field was in the area where today's government center and Cedars of Lebanon Hospital stand, cf. The Miami Metropolis, Dec. 23, 1898, p. 7. The dusty wagon road likely followed today's N.W. Fifth Street to N.W. Seventh Avenue. From that point it may have crossed Wagner Creek (today's Seybold Canal) and proceeded along the river to the drill field or possibly it turned north along today's N.W. Seventh Avenue to N.W. Eighth Street Road then west along N.W. Eleventh Street.
27. The mosquito transmission of malaria had been demonstrated by Ronald Ross only the year before and it is likely not many of the Army surgeons had accepted this discovery.
28. Report of the Commission Appointed by the President to Investigate the Conduct of the War Department in the War With Spain. Eight Volumes. Washington: Government Printing Office, 1899, 56th Congress, 1st Session, Senate Document #221, Vol. 8, p. 83. Hereinafter listed as "Dodge Commission."
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31. Dodge Commission: Vol. 1, p. 651.
32. Raymond, Henry L., War Articles. Medical Organization of the Camp at Tampa, Florida, Medical News, New York, 72:590-591, (May 7), 1898
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34. The Miami Metropolis, July 22, 1898, p. 4; Dodge Commission, Vol. 8, pp. 93-94.
35. Dodge Commission, Vol. 6, pp. 2870-2871 and 2874.
36. Ibid, p. 2875.
37. Dodge Commission, Vol. 8, p. 93.
38. Ibid, Vol. 8, p. 93.
39. Two of the Camp Miami suicides were surgeons, cf. Dodge Commission, Vol. 6, p. 2881.
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41. The Miami Metropolis: Sept. 2, 1898, p. 1898, p. 2.

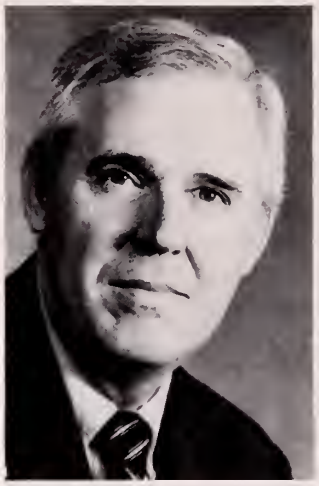
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History of graduate medical education at the University of Florida

J. Lee Dockery, M.D.

Graduate medical education (residency training) in the United States is recognized and accepted as an essential phase of medical education. The principal purpose of this training is for physicians to develop knowledge and skills which will permit them to engage in the independent practice of medicine. Graduate medical education begins at graduation from medical school and ends sometime after the educational requirements for one of the medical specialty certifying boards have been completed. The length of graduate medical education varies from three to seven years. The term "residency" is commonly used to describe the time an individual spends in graduate medical education and the term "resident" is used to identify those physicians pursuing graduate medical education in a residency training program. The term "resident" is derived from the concept in the era in which physicians involved in graduate medical education were expected to reside in the hospital on a full-time basis. Although few residents are now expected to reside full-time in teaching hospitals, the name "resident" is still used and distinguishes this specific group of physicians as trainees.

Traditional education • Traditionally, graduate medical education has been hospital based or combinations of an inpatient experience as well as an outpatient experience. Earlier in this century it was common for recent graduates of medical school to spend a year of "internship" in a hospital to gain practical experience. Some individuals spent the training year



in hospitals affiliated with or owned by medical schools, but for the most part the internship was spent in a hospital not affiliated with any medical school. Prior to the second half of the 19th century, the majority of graduates either entered practice immediately or became apprentices to an older physician with an established practice to learn additional skills. However, in this period of our history there were very few medicines which were disease specific and surgical procedures were limited until the introduction of ether anesthesia in 1846. Also during this period of time there were few hospitals in the United States, and, therefore, the possibility of a broad clinical experience with supervision was severely limited.

By the early 1900s however, many hospitals had developed and surgery had become the specialty of the greatest prestige. At this time it is estimated that more than half of all medical graduates were doing internships because it was only possible to receive the necessary training and experience in a hospital based setting. A few hospitals provided an additional period of residency training after the internship which was for specialty preparation. By 1920, 15 distinct specialties in graduate medical education had developed. Although now the accreditation process for each residency training program is firmly established, during the 20 years between 1920 and 1940 the supervision of the residency training program and the accreditation process was unclear and the university, hospital, National Board of Examiners, and Council of Medical Education of the American Medical Association all claimed some degree of control and responsibility for the quality of each residency train-

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Table 1.—Accredited Residency Training Programs.

Medicine	1958-59	Pediatric Cardiology	1960-61	Otolaryngology	1962-63
OB/GYN	1958-59	Child Psychiatry	1960-61	Neurological Surgery	1963-64
Pathology	1958-59	Radiology	1960-61	Plastic Surgery	1965-66
Pediatrics	1958-59	Neurology	1961-62	Radiation Therapy	1969-70
Psychiatry	1958-59	Orthopedic Surgery	1961-62	Community Health and Family Medicine	1974-75
Surgery	1958-59	Thoracic and Cardiovascular Surgery	1961-62	Neuropathology	1977-78
Urology	1958-59	Ophthalmology	1962-63		
Anesthesiology	1959-60				

ing program. However, the process was not standardized, and discussions occurred over the length of period of training, assignment of responsibility for defining goals, and content of the graduate medical education curriculum was variable and ill defined. In some instances the hospital had specified the duties and training requirements of residents, and in other circumstances, even within the same institution, a clinical service would determine the content of training.

Accreditation process • With the development of specialty boards, the specification of time and experience has greatly improved the quality of graduate medical education programs. The accreditation process established by the Accreditation Council for Gradute Medical Education establishes information available to each medical school graduate about each of the approximatley 5,000 accredited graduate programs in medical education in the United States. The Accreditation Council is composed of representatives of the American Board of Medical Specialities, American Hospital Association, American Medical Association, Association of Medical College and Council of Medical Specialty Societies. In addition, the federal government names a representative to serve as a nonvoting member and the Council chooses one public member. Each program in graduate medical education, upon request to the Accreditation Council, may be reviewed by a Residency Review Committee which consists of representatives appointed by the American Medical Association, the appropriate specialty board and in some cases a national specialty society. A residency training program desiring accreditation must complete an application for a survey which supplies a standard amount of information concerning characteristics of the respective residency training program. The program is then surveyed against a set of general essentials and specialty requirements for accredited residencies.

Today, more than 1,700 hospitals provide over 74,000 residency training positions in over 5,000 accredited residency training programs in 24 separately established, recognized specialties. Of the 74,000 available residency training positions, approximately 21,000 are available for first year training positions for the graduates of the 127 accredited medical schools in the United States.

Residency training • The University of Florida College of Medicine, by national standards, is a very young medical school having admitted its first class in 1956 and graduating 40 students in 1960. At the present time the University of Florida has 21 accredited residency training programs and ten fellowship programs. The chronology of the establishment of the accredited residency training programs is listed in Table 1.

In 1958-59, the first year the University of Florida College of Medicine established accredited residency training programs, 47 trainees were accepted into the seven established accredited programs. In 1967-68, almost ten years later, 160 trainees were accepted into the 18 accredited programs. And now, almost 30 years after the first programs were established, 427 residents and fellows are participating in the 21 various accredited residency training and fellowship programs located at Shands Hospital and the Veterans Administration Medical Center in Gainesville.

In the analysis of the professional activities of the alumni during the first 20 years of the University of Florida College of Medicine, 45% of 1,274 alumni have chosen primary care fields and 55% have chosen other specialty care fields. If obstetrics and gynecology is included in this figure, the primary care effort increases to 52%. Residency training programs provide an important adjunct to the education and training of students in colleges of medicine. The combination of medical student, resident physician, and faculty in the evalutaion of treatment of patients augments the experience of each individual and improves medical care available to the citizens of a community.

The Graduate Medical Education system in the United States is the envy of the world, of which the University of Florida is a prestigious and integral component.

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The residency program at the University of South Florida

Janifer M. Judisch, M.D.

While the University of South Florida's residency program officially began in 1972, the Tampa medical community has a long history of commitment to graduate medical education. The first internships were offered in 1935, 33 years before the medical school was established.

Early trainees • Most physicians when asked to describe their training program will make some comment to the effect that they were overworked and underpaid. This was certainly true for those early trainees at what was then called the Tampa Municipal Hospital. Dr. Lewis Corum, retired Tampa pediatrician, remembers well his working seven days a week with no vacation and no weekends off. These trainees were expected to work three nights in a row and then have three nights "off." They were paid $25 a month plus room, board and laundry, but $5 a month was deducted for uniforms which did not fit. While Dr. Corum is quick to point out that cigarettes were only 5 cents a pack in those days, he also notes that there was only one drug salesman who interacted with the house staff. By contrast, staff physicians were paid $50 a month to bring their patients to Tampa Municipal Hospital. These conditions are considerably different than those experienced by today's house staff. It is of interest that in the same time frame, the cost to the hospital for each paying patient was $5.11 per day, which represented a 17% increase during the preceeding four years.

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Like most hospitals, what is now known as Tampa General Hospital experienced an acute shortage of physicians of all varieties during the war years. Following this time, many realized the need to better organize the graduate educational program and to obtain accreditation. The first such programs in surgery and otolaryngology were accredited in 1949 under the leadership of Drs. Frank Chunn and J. Brown Farrior. The program continued to expand and grow so that a Department of Education was established in 1957 under the direction of Dr. David Baumann. That department subsequently was responsible for rotating internships and residencies in internal medicine, obstetrics-gynecology, otolaryngology, pathology, pediatrics, radiology, surgery, and urology until the educational responsibility was shifted to the University of South Florida College of Medicine.

Residency programs • The College of Medicine was established by statute in 1968. The first class was admitted in 1971 and Tampa General Hospital has served as its major teaching facility. An affiliation agreement between USF and Tampa General Hospital was signed in 1969 and the medical school assumed the educational responsibilities for the residency programs in 1972. Before the medical school, all residents were supervised by volunteer physicians in private practice who, despite valiant efforts, were unable to maintain full accreditation for the existing programs. Arrival of

the full-time faculty culminated in successful efforts to increase the educational activities, to improve the clinical experience of the residents and to bring the programs into compliance with national standards which required that full-time physicians supervise the residency training. The late Dr. Jack Hickman served as the first coordinator of the residency programs for the medical school.

Change to a "university program" did not occur without some conflict. By good faith negotiation by all parties, the fears, anxities and control issues that invariably arose had been addressed.

Most medical schools may have the good fortune to be associated with the opening of a new hospital during the tenure of any one administration. USF has been involved in planning and eventual opening of four new hospitals during its relatively short life.

The first such hospital was James A. Haley Veteran's Administration Hospital, a Dean's hospital, located across the street from the medical school. There are invariably some oversights as any new hospital is opened and this hospital was no exception. In planning for the operating rooms, shoe covers were inadvertently omitted. It is recorded that the first operations were done by USF faculty members in their stocking feet.

In 1972, when the University of South Florida program was developed, there were 72 young physicians in training. There are now more than 350 residents and fellows in virtually all specialty and subspecialty areas. Tampa General Hospital and the James A. Haley Veterans Administration Hospital form the basis of the medical school's graduate educational program. The 1987 National Resident Matching Program results listed the USF program as having 61 PGY 1 slots initially available with 60 filled during the match, one of the best records in the state.

In the last three years, the USF College of Medicine has placed residents in the newly opened Shrine Hospital-Tampa Unit, University Diagnostic Institute, H. Lee Moffitt Cancer Center, and the University Center for Psychiatry. Each of these facilities was placed on the University campus because the governing bodies recognized the advantage to their facilities in being closely associated with the teaching and research missions of a college of medicine. The medical school in return has been able to add breadth and depth to its teaching at all levels and to increase its research potential.

In the early 1980s, residency programs throughout the country experienced unrest and conflict. Tampa was no exception and in 1982 there was a four-day "walk-out." The issues were those that have plagued residency programs for years, such as the quality of on-call rooms and residents getting the respect from all concerned that they deserved as hard working young physicians. The story was extensively covered by the local press. What reporters did not write about, because they did not know or understand, was the high degree of responsibility demonstrated by these young physicians. Most deplored what they were doing but felt they had no other avenue left open to them. The faculty of the College of Medicine stepped in and covered for them. None of the residents left their post until the faculty member had arrived and been thoroughly briefed. The senior residents left the hospital carrying their beepers with the admonition to their faculty replacement to call them any time if any problem arose that the faculty members felt they could not handle. The residents continued to call back at regular intervals to make sure that the faculty was doing "OK."

Residents and medical students are what make a teaching hospital. Although a hospital may be an excellent hospital without these young students, it is not the vibrant, exciting place that offers stimulation, aggravation and productivity. They have an infuriating habit of keeping you from becoming intellectually lazy. As furious as we all get periodically because the resident "forgets" to do something we told them to do or, worse yet, discharges one of our patients without telling us about it, I cannot imagine practicing in a setting without them. I am proud to be a part of a medical community that has a long history of taking the time and effort to teach those coming along behind us just as in past years someone felt the obligation to teach us.

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History of the Pensacola educational program

Richard D. Nauman, M.D.

The idea of founding a graduate medical education program in a community setting began in 1959 and became a reality in 1961 on the recommendation and support of members of the Escambia County Medical Society with the cooperative efforts of three hospitals—one public and two private. Originally, the Intern-Resident Committees of two private hospitals and the local medical society merged into a single training effort in December 1959 with the first "D.M.E." being a young surgeon just beginning his practice locally. Such a training program was designed with four primary objectives: (1) to provide graduate training by qualified and interested physicians with a teaching background in a community setting, (2) to provide a source of practicing physicians for the community, in 1959 there was a definite need to increase the number of practicing physicians in Pensacola, (3) to provide readily available on-sight continuing medical education for local physicians outside a medical school, (4) and probably most important to provide excellent care for economically disadvantaged or underfunded patients. Prior to this time each hospital had its own training program filled primarily with foreign medical graduates. The fledgling combined program began with two programs—Rotating General Practice Residency and Rotating Internship.

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Dr. Nauman, formerly Rear Admiral, Medical Corps, United States Navy, after 35 years of active duty retired in 1977 and on September 12, 1977, became the final Director of Medical Education for the Pensacola Educational Program until January 1, 1987. Dr. Nauman has been a regular columnist for the Escambia County Medical Society "Bulletin" since January 1979.



Members of the medical society and local practicing specialists provided their services as teaching faculty on a strictly volunteer basis.

In 1960 a Board of Directors was formed with several specialists, hospital administrators and two interested businessmen but soon included more hospital administrators and representatives of the professional staff of each hospital, the Escambia County Medical Society, several prominent educational institutions, and the community-at-large. In October 1960, the intern/resident training program was named the "Pensacola Educational Program" and about a year later a full-time D.M.E. and secretary were hired. Thus, the P.E.P. "Staff" was founded. The next several years found the program facing problems of organization, financial support, recruiting, and national recognition. In 1964, however, P.E.P. became a Foundation when it filed its charter with the Florida Secretary of State and became the "Pensacola Foundation for Medical Education and Research, Inc."

Residency programs • In 1965 the Program began to gather momentum—the first specialty residency program in Ob/Gyn was initiated; a new D.M.E. was employed who was more knowledgeable regarding the national trends of medical education and could insert more undivided effort and professional sophistication in behalf of the Program. (Dr. Bill White was truly the real founding D.M.E. in the Program having served

from 1965 until September 1977 at which time the author began). It should be noted that P.E.P., though not a pilot program, was unique in that only a very few similar programs like it existed in the United States (with probably the Penrod Program in Indiana being the first) and like similar programs was not associated directly with a teaching institution (i.e., university medical school) and associated hospital, but as an adjunct or supportive service of a general or private hospital.

In the next five years six national specialty boards approved training in P.E.P.—Ob/Gyn, previously mentioned, Surgery, Internal Medicine, Pediatrics, Pathology, Anatomy and Clinical Pathology, and Rotating Internships. The General Practice Program and the Pathology Programs were subsequently discontinued due to lack of interest. However, loss of interest in these two programs was counteracted by the increased interest in the rotating internships ("Flex" Program). The ever-popular regional monthly Externship (Clinical Clerkship) in 1968 included 20 students from ten different medical schools, mostly regional, and proved to be an excellent recruiting tool. Moreover, in the years to come, interest would be generated in the Family Practice and Emergency Medical Service Programs.

It was during this period that full-time directors in all major clinical services in support of the residency programs were appointed as managerial, administrative and more sophisticated teaching and recruitment efforts. The original staff of one director and one secretary was expanded through necessity to support an ever-growing program. The administrative offices moved into Baptist Hospital, with other support offices being eventually located in Sacred Heart and Escambia General (University) Hospitals. The primary administrative office initially located in Baptist was moved to Sacred Heart Hospital in 1968 with other support administrative offices located in University Hospital. The administrative, financial, planning, and recruitment responsibilities were transferred from the University Hospital though the specialty offices still retained the primary responsibility of their particular program. Following this restructuring, P.E.P. was approved as a nonprofit tax-exempt organization by the IRS.

Funding • The fiscal portion of the foundation was started in 1968 when the hospitals agreed to transfer the payroll and other related administrative functions from the business and personnel offices of the three hospitals to the General Fund of P.E.P. About the same time, the first of the specialty funds, Ob/Gyn, agreed to transfer its fund from a private account into the newly formed fiscal foundation. Surgery, Internal Medicine, and Pediatrics soon followed in a like manner. It should be noted that though the original funding for the earlier participants was primarily on a fee-for-service basis in which these monies earned by the attendant and trainee were the basis of the specialty funds, the entire program in its administrative ramifications required support to be supplied by the participating hospitals as well as the specialty funds.

Even in the earlier years, with the rapid growth of the entire program, the funding became more involved, especially with the establishment of a Foundation Fund as an umbrella to encompass the various specialty funds. It was soon discovered that no one single fund could completely support the needs on a day-to-day basis and at all times remain solvent. Furthermore, with the tremendous growth of the program, the single fee-for-service would be insufficient to continue expanding educational programs and meet all adminstrative needs in spite of donations, memorials, private funds, etc. Various grants were obtained over the years from federal, state, and local organizations to promulgate the established programs and "build the future".

Since its inception approximately 350 physicians have trained in P.E.P. About 68 have stayed in Florida to practice and 52 remained in the Panhandle with 40 staying in Pensacola to practice. About 20 located in the neighboring state of Alabama. Though the major thrust of interest has been in Southeast United States, there were few of the 50 states that were not well aware of or have been represented by the Program. There were a number of graduates of recognized medical schools in foreign countries and U.S. osteopathic schools that also participated in the Program. The popularity of the Program was not so much its locale, a resort atmosphere, but in its emphasis on student responsibility, its diversification, its almost one-to-one attendant/trainee relationship and especially on the solidarity and strength in educational results—its trainees generally became Board Certified.

P.E.P. was unique as mentioned before in that it was not associated directly with any one medical school. It had established and maintained a close relationship with medical schools in most all of the Southeast United States and was quickly recognized as an excellent opportunity for graduate medical education with numerous other hospitals and medical institutions—some far removed. While maintaining its own popular program, P.E.P. had also served as a model for other similar programs in Texas, Indiana, Alabama, West Virginia, Ohio, and several New England states.

Training and patient care • From the onset of P.E.P., patient care through the aegis of a training program was paramount and academia was necessarily regarded of equal importance. Weekly conferences and lectures were conducted in all major clinical services as part of their training and it is interesting to note that many of these were attended by local practicing physicians as well.

In the earlier years bimonthly lectures, which

were to become the forerunners of expanded seminars, were presented by visiting professionals with academic research acumen from major medical academic institutions throughout the United States. These seminars and lectures related to various specialty and subspecialty areas and were well attended by the residents, medical staffs, and area physicians. In time, large seminars in each specialty area featuring nationally and internationally prominent specialists occurring two to three times per year enhanced the regular programs academia as well as promoted the increasing interest for C.M.E. of area physicians.

In 1974 the program sought and received full approval for sponsorship in all categories for CME accreditation by the AMA for four years which was extended to six years in 1978. The significance and importance of CME was thus acknowledged and was the basis of the formation of MECOP—Medical Educational Council of Pensacola in 1986, when P.E.P., as such would phase out.

In 1975 an umbrella affiliation with the University of Florida was concluded and in 1976 a fourth hospital, West Florida, was added. In later years affiliations were established with Tulane and South Alabama. The year 1975 also saw the abolishment of pathology training for lack of interest. But the other programs were growing and we started a Family Practice Program in 1978 with only three residents—eventually to become 15 and that same year attempted to begin an Emergency Medicine program. The latter only lasted for 18 months and was not fully accredited by the then newly formed surveying group. P.E.P. continued to grow during the late 1970s especially with local physician and hospital support but funding became rather critical as federal funding and national private grants became nonexistent and state support began to diminish. The burden fell on the local hospitals and small donations as there was no firmly established endowment fund.

Even so, 1975 saw a total of 29 residents and a limited number of externs which increased to 54 in 1980, 61 in 1981, and 59 in 1982 with an average of two clinical clerkships per month in several of the residencies. Most of these clinical clerks came from various southeast schools and enhanced our recruiting efforts in the matching program. There were very few areas of the United States except the Northwest, West Coast, and Northeast that were not represented in the Program and each year we would interview 80 to 120 students for 18 to 24 first-year positions. Ours seemed to be one of the more popular community-based programs in the southeast though competition with the larger more established university programs became greater with each passing year.

Program changes • The early 1980s saw many changes within the Program. There were several programs with Directorship turnovers; the programs had a slight increase in total number of foreign medical graduates; financial support became more difficult; we were confronted with a couple of malpractice suits; problems with local politics; and a number of our volunteer attending faculty who had supported us since the beginning just "burned out". The local public or county supported hospital, University, which had been for years the real base of the Program had severe management and financial problems and it became necessary to relocate the P.E.P. to two other hospitals. The Transitional Program which had always been one of the most popular could no longer be supported and was, therefore, discontinued. The Internal Medicine program, which had difficulty in recruiting in the early 1980s, had lost some of its academic prestige, and was put on probation in 1983 and finally discontinued in 1985. The Surgery program had similar problems and it too was discontinued in 1985. The Family Practice Program, which once had a bright future, transferred its activities and training to University Hospital in 1984 as a result of liaison incompatibilities with several other programs. This proved to be a judgmental error as it was discontinued at the end of the 1986 academic year.

In the middle 1980s other changes had occurred; the Board of Directors was revamped; only two hospitals continued to support the program, there was excessive local political involvement; and recruiting became more difficult. It was realized by the hospitals and the medical community faced with problems of liability insurance, DRGs, cost containment, HMOs, and federal involvement, that having residency training programs almost became a luxury that few institutions could afford. Even so, the Pediatric Residency Program, fully accredited, remains steadfast at Children's Hospital of Sacred Heart and appears to have a bright future. The Ob/Gyn Program which was very recently put on probation is still strong and will become a satellite of the outstanding program at Tulane this summer. It should be noted the present residents in both programs are excellent and all have promising futures.

Need fulfilled • Such was the "Saga of P.E.P.". More than 25 years ago, it was the dream of some outstanding far-sighted physicians, several hospital administrators, a very supportive medical society, and a very appreciative and interested civilian community in a most progressive state. The idea of providing medical care to a goodly number of economically disadvantaged people, increasing the number of practicing physicians to a rapidly developing area, and involving the practicing physicians in continuing medical education through a community-based residency program appeared to be an innovative endeavor. However, the catalyst in the entire concept was the availability of a majority of volunteer physicians, for without their constant sacrifice of time and effort it would have been impossible. Then, too, it occurred at a time when there was federal interest and

support in total population care. Northwest Florida was a fertile area for such a venture since it was rather removed from the core of state medical activity.

In P.E.P.'s early years support was quickly gained from the University of Florida and as the program grew in numbers and proficiency affiliations were also secured from University of South Alabama and Tulane, where we still have firm connections. Though the recruiting efforts have lacked the "gung ho" recruiting organizations, the program had national notoriety as an exceptional area for graduate training. Close rapport with most of the medical schools in the southeast has been maintained from the onset. Furthermore, a harmonious relationship has always been maintained with the American Medical Association, Association for Hospital Medical Education, Association of American Medical Colleges, the National Matching Program, and many other national regulatory bodies concerned with graduate medical education, and the regional area, and local medical and educational organizations and societies.

During the last 20 years many factors have influenced graduate medical education especially in community-based programs. The state of the art has been modified and physicians are practicing more defensively than ever. Health care is big business with extensive federal involvement. At one time there was a national belief that we were producing too many doctors, so there were fewer admissions to medical schools, Medicare and Medicaid seemed to answer most of our problems though adequate indigent care is still a national problem (possibly will soon be replaced by concern for catastrophic care); the acronyms and pseudonyms HMOs, PPOs, DRGs, etc., may replace prn, qid, stat, in our medical language; and presently there seems to be no direct resolution to the liability insurance problem.

P.E.P. was a great idea, begun at a most opportune time in the western Panhandle. It surely put Pensacola on the map. Thanks to those fantastic supportive physicians in the 1960s and 1970s the program attained its primary goals of care for the masses through an educational program. But volunteerism soon burns out just as the economic support has lessened. There are hundreds of practicing physicians today who have trained here, other hundreds locally who have benefitted by having an educational program, and many thousands who have received care otherwise almost unattainable. While graduate medical education continues locally and the support for continuing medical education continues through the Medical Education Council of Pensacola, P.E.P. will remain a very fond memory that fulfilled masterfully a community need. There are a number of community-based programs throughout the country which have suffered a similar fate. It might be said that though we are not "alive and well", graduate medical education and continuing medical education will continue in the Panhandle and we hope for a revival of interest in the "Western gate to the Sunshine State."

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CME in Florida: An historical overview

Robert C. Fore, Ed.D., and Pierre J. Bouis Jr., M.D.

On the first Independence Day of this century, Sir William Osler presented a major address in London entitled "The Importance of Post-Graduate Study".[1] In the second sentence he came directly to the heart of his presentation: ". . . More clearly than any other, the physician should illustrate the truth of Plato's saying, that education is a lifelong process." Osler warned against the trend toward specialization citing the ". . .benumbing influence of isolation" and stressed the importance of study beyond medical school for "refreshment and renovation". On medical school training, he stated further that it ". . . gives a man his direction, points him the way, and furnishes him a chart, fairly incomplete, for the voyage, but nothing more."

The concept of a medical education continuum as described by Coggeshall[2] and Mayer[3] has generally been accepted to include premedical education, medical school, graduate medical education (GME) and continuing medical education (CME). The last phase of the continuum encompasses the greatest length of time spanning upwards of 40 years of productive medical practice. Physicians have traditionally turned to medical journals, periodicals and consultations to extend their medical knowledge while formal continuing medical education activities have rapidly increased in number and scope in recent years.

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Leadership in continuing medical education in Florida is today assumed by the Florida Medical Association (Table 1), Florida Medical Foundation, University of South Florida College of Medicine, University of Florida College of Medicine, University of Miami School of Medicine and a wide array of community hospitals, specialty societies, and voluntary health care organizations. This brief historical overview will outline the development of continuing medical education in Florida from the perspective of the Florida Medical Association.

While the label "continuing medical education" had not yet been adopted by the Florida Medical Association, as early as 1958 the FMA Medical Postgraduate Course Committee set the foundation for the Association's involvement in CME by listing the functions of the Committee: Represent the FMA in sponsoring postgraduate courses; Offer advice and coordination to prevent duplication of effort; Perform a certain amount of investigation; and Publicize courses and encourage doctors to undertake postgraduate courses.

Table 1.—Top FMA Leadership in CME.

1958	Turner Z. Cason, M.D.*
1959	Turner Z. Cason, M.D.
1960	Donald F. Marion
1960-64	Thad Moseley, M.D.**
1964-71	Richard C. Dever, M.D.***
1971-72	O. William Davenport, M.D.
1972-73	James M. Ingram, M.D.
1973-75	Gerold L. Schiebler, M.D.
1975-77	J. Lee Dockery, M.D.
1977-82	Yank D. Coble, M.D.
1982-84	Henry M. Yonge, M.D.
1984-	Pierre J. Bouis Jr., M.D.

* Recognized for his 27 years as Chairman of the Medical Postgraduate Course Committee.
** Chairman of the Scientific Council.
*** Scientific Council became Council on Scientific Activities in 1968.

At the 1965 Annual Meeting, the Scientific Council reported that 33 postgraduate courses had been approved the previous year and that ". . .the geographical distribution of programs has not been ideal, particularly from the standpoint of the counties in the western part of the state."[4]. The Council further recommended that it ". . .become more active in working with medical schools toward the establishment of a better program of continuing education for the practicing physicians of Florida."[5]

In 1966 the Committee on Postgraduate Education explored ways to better coordinate postgraduate programs between medical schools and hospitals and welcomed the appointment of Thomas D. Bartley, M.D., as Assistant Dean of Postgraduate Education at the University of Florida College of Medicine and Jerome H. Modell, M.D., as Coordinator of Postgraduate Education at the University of Miami School of Medicine.[6] Several proposals were studied to make continuing medical education more available including radio and television links between medical schools and hospitals, traveling teaching teams from medical schools and regional seminars.

Mandatory credit ● The subject of mandatory continuing medical education was a major issue facing the newly named Council on Scientific Activities in 1969 and it was recommended that participation in continuing education programs should not be required for membership at that time.[7] Two years later, the name of the Committee on Postgraduate Education was changed to the Committee on Continuing Medical Education to be consistent with current national terminology.[8] At the October 1971 Board of Governors meeting, the Council on Scientific Activities reported consideration of a 30 hour per year continuing medical education requirement to maintain membership in the Florida Medical Association. At the subsequent Annual Meeting the Florida Medical Association Mandatory Continuing Medical Education Program was begun on May 6, 1972 when the House of Delegates decreed:

> "That 30 hours of continuing medical education be established as a minimum requirement for maintenance of Association membership to become effective January 1, 1974, with guidelines and procedures for fulfilling this requirement to be developed by the Committee on Continuing Medical Education for presentation to the House of Delegates in 1973."[9]

One year later, on May 12, 1973, the House of Delegates approved the basic format for the mandatory continuing medical education program which required 90 hours within a three-year cycle with a minimum of 60 "mandatory" hours. At that time there were few accredited institutions in Florida with authority to approve AMA Category I credit. Therefore, in an attempt to increase the availability of quality programs, FMA "Mandatory Credit" was created so that many local opportunities for involvement were guaranteed. The continuing education requirement underwent several modifications and was expanded to include 150 hours with a minimum of 60 "mandatory" hours within a three-year cycle. Initially members were allowed to begin their cycle on January 1, 1974; January 1, 1975 or January 1, 1976. Reporting was required directly to county medical societies.

At its March 9, 1974 meeting the Council on Scientific Activities unanimously recommended to the Board of Governors that a statewide plan be developed relating to the accreditation of CME programs which did not have direct review by the AMA. Such programs were to be evaluated only upon the request of the sponsoring group or institution.[10]

On March 28, 1974 Rutledge W. Howard, M.D., Associate Director, AMA Division of Medical Education, met with the FMA Committee on Continuing Medical Education to instruct its members on the AMA's accreditation program and how the FMA could assume this function for intrastate sponsors of CME. On April 19, 1974 the FMA forwarded its application to the AMA Advisory Committee on Continuing Medical Education and on July 1, 1974 the FMA was notified of approval of its Continuing Medical Education Accreditation Program. The first institution accredited by the FMA was the Halifax Hospital Medical Center, Daytona Beach, on October 24, 1974. The accreditation program has continued resulting in 25 FMA accredited CME sponsors at present.

As the University of South Florida College of Medicine prepared to graduate its first class in 1974, Florida's third medical school officially entered the continuing medical education arena with the appointment of Theron A. Ebel, M.D., as Assistant Dean for

Continuing Medical Education. Subsequently the relationship between the Florida Medical Association and each medical school has been strengthened with appointment of the respective deans to the FMA Committee on Medical Education and cosponsorship by each medical school of the FMA Annual Meeting Scientific Program.

In 1981 the newly created Accreditation Council for Continuing Medical Education (ACCME) became the national accrediting body for CME and developed a set of "Essentials" for the provision of quality continuing medical education programs.[11] These "Essentials" were revised and became effective January 1, 1984 to be applied to all national and intrastate CME sponsors. In addition to its role as the accreditor of national CME sponsors, the ACCME, through its Committee for Review and Recognition (CRR), established an aggressive review process for the recognition of state medical associations as accreditors of intrastate CME sponsors. On November 21, 1986, the FMA Committee on Medical Education underwent its first on-site review by representatives of the CRR and on May 14, 1987, was awarded the maximum allowable four-year period of continued recognition.

Relicensure credit • As a result of the 1985 session of the Florida legislature, physicians were for the first time required to accumulate CME credits for relicensure. The biennial requirement mandated 40 hours of continuing medical education with at least five hours in risk management. Acceptable credits included AMA Category I, American Academy of Family Physicians Prescribed Credit, and American College of Obstetrics and Gynecology Cognates. This new requirement coupled with the growing number of accredited CME sponsors in the state made FMA "mandatory" credit obsolete. As a result, the Council on Scientific Activities recommended to the Board of Governors at its October 19, 1985 meeting that mandatory credit be discontinued effective February 1, 1986 to be replaced by Category I, Prescribed, or Cognates.

Although the Board of Medicine's requirements for relicensure became effective the first biennium beginning on January 1, 1986 and ending December 31, 1987, the FMA membership requirements remained unchanged leaving physicians on three overlapping three-year cycles. The Council on Scientific Activities recognized the problems involved in requiring FMA members to keep up with one requirement for relicensure and a different requirement for maintaining Association membership. As a result, on January 31, 1987 the Board of Governors approved a Council of Scientific Activities recommendation that the current CME requirement for membership be ammended to conform to state relicensure requirements. An additional feature of the recommendation was to establish the first reporting period effective the biennium between January 1, 1988 to December 31, 1989 with reporting to be directly to the Florida Medical Association. The recommendation was unanimously approved and will be presented to the House of Delegates at the 113th Annual Meeting on September 16-20, 1987.

Summary • The Florida Medical Association will continue to occupy its role as a leader in continuing medical education. Recognizing the need to anticipate and respond to rapid change in the practice of medicine will continue to be the central concern of the Council on Scientific Activities. One of Sir William Osler's heroes was the British physician Thomas Browne who wrote in the introduction to his work *Pseudo Epidemica* (Epidemic False Beliefs) published about 1650, that ". . .knowledge is made by oblivion, and to purchase a clear and warrantable body of truth, we must forget and part with much we know." Technological and scientific advances may indeed require physicians to part with much of what they have learned as they develop new skills and knowledge through the final phase of their medical education.

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ceftriaxone sodium/Roche

* ROCEPHIN is indicated in the following infections: bacterial septicemia, bone and joint, intra-abdominal, lower respiratory tract, skin and skin structure, urinary tract, bacterial meningitis and gonorrhea. Please see summary of product information on adjacent page for indicated susceptible organisms.

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Please see adjacent page for summary of product information.

Rocephin® IV·IM

ceftriaxone sodium/Roche

Before prescribing, please consult complete product information, a summary of which follows:

MICROBIOLOGY The bactericidal activity of ceftriaxone results from inhibition of cell wall synthesis Ceftriaxone has a high degree of stability in the presence of beta lactamases, both penicillinases and cephalosporinases, of gram-negative and gram-positive bacteria Ceftriaxone is usually active against the following microorganisms *in vitro* and in clinical infections (see Indications and Usage)

GRAM-NEGATIVE AEROBES Enterobacter aerogenes, Enterobacter cloacae, Escherichia coli, Haemophilus influenzae (including ampicillin-resistant strains), *H parainfluenzae, Klebsiella* species (including *K pneumoniae*), *Neisseria gonorrhoeae* (including penicillinase and nonpenicillinase producing strains) *Neisseria meningitidis, Proteus mirabilis, Proteus vulgaris, Morganella morganii* and *Serratia marcescens*

Note Many strains of the above organisms that are multiply resistant to other antibiotics, e g. penicillins, cephalosporins and aminoglycosides, are susceptible to ceftriaxone sodium

Ceftriaxone is also active against many strains of *Pseudomonas aeruginosa*

GRAM-POSITIVE AEROBES Staphylococcus aureus (including penicillinase-producing strains) and *Staphylococcus epidermidis* (Note methicillin-resistant staphylococci are resistant to cephalosporins, including ceftriaxone), *Streptococcus pyogenes* (Group A beta hemolytic streptococci), *Streptococcus agalactiae* (Group B streptococci) and *Streptococcus pneumoniae* (Note Most strains of enterococci, *Streptococcus faecalis* and Group D streptococci are resistant)

Ceftriaxone also demonstrates *in vitro* activity against the following microorganisms, although the clinical significance is unknown

GRAM NEGATIVE AEROBES Citrobacter freundii, Citrobacter diversus, Providencia species (including *Providencia rettgeri*), *Salmonella* species (including *S typhi*), *Shigella* species and *Acinetobacter calcoaceticus*

ANAEROBES Bacteroides species, *Clostridium* species (Note most strains of *C difficile* are resistant)

SUSCEPTIBILITY TESTING Standard susceptibility disk method Quantitative methods that require measurement of zone diameters give the most precise estimate of antibiotic susceptibility One such procedure (Bauer AW, Kirby WMM, Sherris JC, Turck M Antibiotic Susceptibility Testing by a Standardized Single Disk Method, *Am J Clin Pathol* 45 493-496, 1966, Standardized Disk Susceptibility Test, *Federal Register* 39 19182-19184 1974 National Committee for Clinical Laboratory Standards, Approved Standard ASM 2, Performance Standards for Antimicrobial Disk Susceptibility Tests, July 1975.) has been recommended for use with disks to test susceptibility to ceftriaxone

Laboratory results of the standardized single-disk susceptibility test using a 30-mcg ceftriaxone disk should be interpreted according to the following three criteria

1 Susceptible organisms produce zones of 18 mm or greater, indicating that the tested organism is likely to respond to therapy
2 Organisms that produce zones of 14 to 17 mm are expected to be susceptible if a high dosage (not to exceed 4 gm per day) is used or if the infection is confined to tissues and fluids (e g., urine), in which high antibiotic levels are attained
3 Resistant organisms produce zones of 13 mm or less, indicating that other therapy should be selected

Organisms should be tested with the ceftriaxone disk, since ceftriaxone has been shown by *in vitro* tests to be active against certain strains found resistant to cephalosporin class disks

Organisms having zones of less than 18 mm around the cephalothin disk are not necessarily of intermediate susceptibility or resistant to ceftriaxone

Standardized procedures require use of control organisms The 30-mcg ceftriaxone disk should give zone diameters between 29 and 35 mm, 22 and 28 mm and 17 and 23 mm for the reference strains *E coli* ATCC 25922, *S aureus* ATCC 25923 and *P aeruginosa* ATCC 27853, respectively

DILUTION TECHNIQUES Based on the pharmacokinetic profile of ceftriaxone, a bacterial isolate may be considered susceptible if the MIC value for ceftriaxone is not more than 16 mcg/ml Organisms are considered resistant to ceftriaxone if the MIC is equal to or greater than 64 mcg/ml Organisms having an MIC value of less than 64 mcg/ml, but greater than 16 mcg/ml, are expected to be susceptible if a high dosage (not to exceed 4 gm per day) is used or if the infection is confined to tissues and fluids (e g, *urine*), in which high antibiotic levels are attained

E coli ATCC 25922, *S aureus* ATCC 25923 and *P aeruginosa* ATCC 27853 are also the recommended reference strains for controlling ceftriaxone dilution tests Greater than 95% of MICs for the *E coli* strain should fall within the range of 0 016 to 0 5 mcg/ml The range for the *S aureus* strain should be 1 to 2 mcg/ml, while for the *P aeruginosa* strain the range should be 8 to 64 mcg/ml

INDICATIONS AND USAGE: Rocephin is indicated for the treatment of the following infections when caused by susceptible organisms

LOWER RESPIRATORY TRACT INFECTIONS caused by *Strep pneumoniae, Streptococcus* species (excluding enterococci), *Staph aureus, H influenzae, H parainfluenzae, Klebsiella* species (including *K pneumoniae*), *E coli, E aerogenes, Proteus mirabilis* and *Serratia marcescens*

SKIN AND SKIN STRUCTURE INFECTIONS caused by *Staph aureus, Staph epidermidis, Streptococcus* species (excluding enterococci), *E cloacae, Klebsiella* species (including *K pneumoniae*), *Proteus mirabilis* and *Pseudomonas aeruginosa*

URINARY TRACT INFECTIONS (complicated and uncomplicated) caused by *E coli, Proteus mirabilis, Proteus vulgaris, M morganii* and *Klebsiella* species (including *K pneumoniae*)

UNCOMPLICATED GONORRHEA (cervical/urethral and rectal) caused by *Neisseria gonorrhoeae*, including both penicillinase and nonpenicillinase producing strains

PELVIC INFLAMMATORY DISEASE caused by *N gonorrhoeae*

BACTERIAL SEPTICEMIA caused by *Staph aureus, Strep pneumoniae, E coli, H influenzae* and *K pneumoniae*

BONE AND JOINT INFECTIONS caused by *Staph aureus, Strep pneumoniae, Streptococcus* species (excluding enterococci), *E coli, P mirabilis, K pneumoniae* and *Enterobacter* species

INTRA-ABDOMINAL INFECTIONS caused by *E coli* and *K pneumoniae*

MENINGITIS caused by *H influenzae, N meningitidis* and *Strep pneumoniae* Ceftriaxone has also been used successfully in a limited number of cases of meningitis and shunt infections caused by *Staph epidermidis* and *E coli*

PROPHYLAXIS The administration of a single dose of ceftriaxone preoperatively may reduce the incidence of postoperative infections in patients undergoing coronary artery bypass surgery

Although ceftriaxone has been shown to have been as effective as cefazolin in the prevention of infection following coronary artery bypass surgery, no placebo-controlled trials have been conducted to evaluate any cephalosporin antibiotic in the prevention of infection following coronary artery bypass surgery

SUSCEPTIBILITY TESTING Before instituting treatment with Rocephin, appropriate specimens should be obtained for isolation of the causative organism and for determination of its susceptibility to the drug Therapy may be instituted prior to obtaining results of susceptibility testing

CONTRAINDICATIONS: Rocephin is contraindicated in patients with known allergy to the cephalosporin class of antibiotics.

WARNINGS: BEFORE THERAPY WITH ROCEPHIN IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS, PENICILLINS OR OTHER DRUGS. THIS PRODUCT SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. ANTIBIOTICS SHOULD BE ADMINISTERED WITH CAUTION TO ANY PATIENT WHO HAS DEMONSTRATED SOME FORM OF ALLERGY, PARTICULARLY TO DRUGS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE THE USE OF SUBCUTANEOUS EPINEPHRINE AND OTHER EMERGENCY MEASURES.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use

ROCEPHIN® (ceftriaxone sodium/Roche)

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis Cholestyramine and colestipol resins have been shown to bind to the toxin *in vitro*

Mild cases of colitis respond to drug discontinuance alone Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated

When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by C *difficile* Other causes of colitis should also be considered

PRECAUTIONS: *GENERAL* Although transient elevations of BUN and serum creatinine have been observed, at the recommended dosages, the nephrotoxic potential of Rocephin is similar to that of other cephalosporins

Ceftriaxone is excreted via both biliary and renal excretion (see Clinical Pharmacology) Therefore, patients with renal failure normally require no adjustment in dosage when usual doses of Rocephin are administered, but concentrations of drug in the serum should be monitored periodically If evidence of accumulation exists, dosage should be decreased accordingly

Dosage adjustments should not be necessary in patients with hepatic dysfunction, however, in patients with both hepatic dysfunction and significant renal disease, Rocephin dosage should not exceed 2 gm daily without close monitoring of serum concentrations

Alterations in prothrombin times have occurred rarely in patients treated with Rocephin Patients with impaired vitamin K synthesis or low vitamin K stores (e g, chronic hepatic disease and malnutrition) may require monitoring of prothrombin time during Rocephin treatment Vitamin K administration (10 mg weekly) may be necessary if the prothrombin time is prolonged before or during therapy

Prolonged use of Rocephin may result in overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Rocephin should be prescribed with caution in individuals with a history of gastrointestinal disease especially colitis

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY Carcinogenesis Considering the maximum duration of treatment and the class of the compound carcinogenicity studies with ceftriaxone in animals have not been performed The maximum duration of animal toxicity studies was six months

Mutagenesis Genetic toxicology tests included the Ames test, a micronucleus test and a test for chromosomal aberrations in human lymphocytes cultured *in vitro* with ceftriaxone Ceftriaxone showed no potential for mutagenic activity in these studies

Impairment of Fertility Ceftriaxone produced no impairment of fertility when given intravenously to rats at daily doses up to 586 mg/kg/day, approximately 20 times the recommended clinical dose of 2 gm/day

PREGNANCY Teratogenic Effects Pregnancy Category B Reproductive studies have been performed in mice and rats at doses up to 20 times the usual human dose and have no evidence of embryotoxicity, fetotoxicity or teratogenicity In primates, no embryotoxicity or teratogenicity was demonstrated at a dose approximately three times the human dose

There are, however, no adequate and well-controlled studies in pregnant women Because animal reproductive studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nonteratogenic Effects In rats, in the Segment I (fertility and general reproduction) and Segment III (perinatal and postnatal) studies with intravenously administered ceftriaxone, no adverse effects were noted on various reproductive parameters during gestation and lactation, including postnatal growth, functional behavior and reproductive ability of the offspring, at doses of 586 mg/kg/day or less

NURSING MOTHERS Low concentrations of ceftriaxone are excreted in human milk Caution should be exercised when Rocephin is administered to a nursing woman

PEDIATRIC USE Safety and effectiveness of Rocephin in neonates, infants and children have been established for the dosages described in the Dosage and Administration section

ADVERSE REACTIONS: Rocephin is generally well tolerated In clinical trials, the following adverse reactions, which were considered to be related to Rocephin therapy or of uncertain etiology, were observed

LOCAL REACTIONS—pain, induration or tenderness at the site of injection (1%) Less frequently reported (less than 1%) was phlebitis after IV administration

HYPERSENSITIVITY—rash (1 7%) Less frequently reported (less than 1%) were pruritus, fever or chills

HEMATOLOGIC—eosinophilia (6%), thrombocytosis (5 1%) and leukopenia (2 1%) Less frequently reported (less than 1%) were anemia, neutropenia, lymphopenia, thrombocytopenia and prolongation of the prothrombin time

GASTROINTESTINAL—diarrhea (2 7%) Less frequently reported (less than 1%) were nausea or vomiting, and dysgeusia

HEPATIC—elevations of SGOT (3 1%) or SGPT (3 3%) Less frequently reported (less than 1%) were elevations of alkaline phosphatase and bilirubin

RENAL—elevations of the BUN (1 2%) Less frequently reported (less than 1%) were elevations of creatinine and the presence of casts in the urine

CENTRAL NERVOUS SYSTEM—headache or dizziness were reported occasionally (less than 1%)

GENITOURINARY—moniliasis or vaginitis were reported occasionally (less than 1%)

MISCELLANEOUS—diaphoresis and flushing were reported occasionally (less than 1%)

Other rarely observed adverse reactions (less than 0 1%) include leukocytosis, lymphocytosis, monocytosis, basophilia, a decrease in the prothrombin time, jaundice, glycosuria, hematuria, bronchospasm, serum sickness, abdominal pain, colitis, flatulence, dyspepsia, palpitations and epistaxis

DOSAGE AND ADMINISTRATION: Rocephin may be administered intravenously or intramuscularly The usual adult daily dose is 1 to 2 gm given once a day (or in equally divided doses twice a day) depending on the type and severity of the infection The total daily dose should not exceed 4 grams

For the treatment of serious miscellaneous infections in children, other than meningitis, the recommended total daily dose is 50 to 75 mg/kg (not to exceed 2 grams), given in divided doses every 12 hours

Generally, Rocephin therapy should be continued for at least two days after the signs and symptoms of infection have disappeared The usual duration is 4 to 14 days, in complicated infections longer therapy may be required

In the treatment of meningitis, a daily dose of 100 mg/kg (not to exceed 4 grams), given in divided doses every 12 hours, should be administered with or without a loading dose of 75 mg/kg

For the treatment of uncomplicated gonococcal infections, a single intramuscular dose of 250 mg is recommended

For preoperative use (surgical prophylaxis), a single dose of 1 gm administered ½ to 2 hours before surgery is recommended

When treating infections caused by *Streptococcus pyogenes*, therapy should be continued for at least ten days.

No dosage adjustment is necessary for patients with impairment of renal or hepatic function, however, blood levels should be monitored in patients with severe renal impairment (e g, dialysis patients) and in patients with both renal and hepatic dysfunctions

HOW SUPPLIED: Rocephin (ceftriaxone sodium/Roche) is supplied as a sterile crystalline powder in glass vials and piggyback bottles The following packages are available

Vials containing 250 mg equivalent of ceftriaxone Boxes of 10 (NDC 0004 1962-01)
Vials containing 500 mg equivalent of ceftriaxone Boxes of 10 (NDC 0004 1963-01)
Vials containing 1 gm equivalent of ceftriaxone Boxes of 10 (NDC 0004 1964-01)
Piggyback bottles containing 1 gm equivalent of ceftriaxone Boxes of 10 (NDC 0004 1964-03)
Vials containing 2 gm equivalent of ceftriaxone Boxes of 10 (NDC 0004 1965-01)
Piggyback bottles containing 2 gm equivalent of ceftriaxone Boxes of 10 (NDC 0004 1965-03)
Bulk pharmacy containers, containing 10 gm equivalent of ceftriaxone Boxes of 1 (NDC 0004 1971-01)
NOT FOR DIRECT ADMINISTRATION

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The cost of illness: A fresh perspective on the non-crisis in health care costs

Survey a problem through many prisms; such a practice will cast a diversity of insights that will enhance one's chances of discovering a solution.

Anonymous

Antoine Gombauld, the Chevalier de Mere, was a 17th century French nobleman emblazoned with a fondness for gambling. He prospered by wagering that he could roll at least one six in four consecutive throws of a single die. He calculated that the probability of obtaining a six on the first throw of a die was ⅙; therefore, he reasoned, the chance of rolling at least one six on four consecutive rolls was ⅘ or 0.67. He calculated that he would win more frequently than he lost but his winning percentage was slightly greater than 50 wagers in 100—a result disappointingly short of his expected 67% rate of winning. His dissatisfaction lured him into the disastrous decision to alter his bet. He subsequently bet that within a sequence of 24 rolls of two dice that he would roll at least one 12. His reasoning was similar to his original bet. The probability of rolling a 12 on one roll with two dice is $\frac{1}{36}$; with 24 rolls it must be $\frac{24}{36}$ or ⅔. Unfortunately, de Mere's second strategy generated more losses than wins and his fortune dwindled.

Our Frenchman had examined the probability conundrum inadequately and had erroneously calculated the true probabilities. His error rested in his extrapolation of his chance of winning his bet on a single roll to his chances of winning on multiple rolls. His methodology underestimated the chances of his potential for loss. The chance of rolling a six with four rolls of a single die is $1-(\frac{5}{6})^4$, or approximately 0.52. The chance of rolling a 12 with 24 consecutive rolls of two dices is $1-(\frac{35}{36})^{24}$ or approximately 0.49.

De Mere's misinterpretation of the true probabilities typifies the manner with which many humans misconstrue and miscalculate the size or importance of many societal problems. People often fixate upon a misleading facet of the problem and neglect the essence of the issue. A case in point is the current national fuss over the "crisis" in health care costs. The deafening din of political and media clamor over the high costs of health care is misleading. The cost of health care is not the proper issue. The issue, of which health care cost is but one subset, is the cost to society of disease. The cost of disease has multiple components. These include the cost of medical care of which we hear so much; it includes the costs of wages lost because of absence from the job or premature mortality of a wage earner or the loss of household services by the homemaker; it includes the cost of inefficiency and low productivity of a chronically ill person in the workplace; it includes the loss of wages by family members who lose work because of the need to care for the sick person. The social cost of illness, in terms of the psychological costs because of disruption of family life, bereavement, etc., cannot be measured but certainly have an economic impact

Historically economists have looked at only two costs of illness—the direct costs which include those for medical care and indirect costs, which only include the costs of lost wages or household services of the sick person. All other indirect costs of disease are ignored. From 1900 to 1930 indirect costs were 7-8 times larger than direct costs. The differential steadily decreased until 1980 when direct costs surpassed indirect costs for the first time.

The societal costs of disease equal the sum of the cost of medical care (such as hospitalization, physician and dental services, medication, nursing home, laboratory and diagnostic services, etc.) and the costs of lost income that arise from the ill person's

Table 1.—Changes in direct medical care costs, population, per capita direct medical care costs and gross national product, 1965—1985. All dollar amounts are expressed in constant, 1965 dollars, to adjust for the effects of inflation. (Adapted from reference 1, table I).

YEAR	DIRECT MEDICAL COSTS ($) (Bill)	POPULATION (X1,000)	COST/ PERSON	GROSS NATIONAL PRODUCT ($Bill)
1965	41.90	203032	206.38	691.0
1975	77.60	224761	345.26	916.8
1985	123.88	247810	497.88	1269.9

morbidity or mortality. Studies that examine these costs in the mid-1980s fail to correct the data for three important variables: the effect of inflation, the growth in the population and the rise in the inflation-adjusted gross national product. When the numbers are filtered through these corrections a surprisingly different image of health care economics is projected from that which is customarily displayed by the media and policymakers.

The absolute values of direct health care costs burgeoned tenfold from 1965 to 1985—from $41.9 billion to $419.5 billion.[1] Devoid of a deeper peek into the meaning of these expenses, this figure is staggering. However, if one corrects for inflation, direct health care costs increased from $41.9 to $123.8 billion when expressed in constant 1965 dollars (Table 1). This is still a threefold increase in costs. However, the population has increased nearly 25% during those two decades from 203 to 248 million people. If the numbers are expressed both in constant dollars and as cost per person, the increase in direct health care costs is proportionately still less: from $206.38 in 1965 to $497.88 per person in 1985—a 2.4 fold increase. However the gross national product has expanded in real dollars from $691 to $1270 billion during these same two decades—a 1.84 fold increase. The nation is wealthier and the health care industry, like the computer, communication and other industries, has economically expanded faster than the rest of the economy. It seems appropriate that the population be allowed to invest in an industry that provides both economic and noneconomic rewards. The factorial growth in health care per capita (2.4) has only slightly exceeded the growth in the economy as a whole (1.84) from 1965 to 1985.

The size of health care cost increase is large but is similar in scope to the increase in size of other technologically sophisticated industries. When observed from this perspective, hysteria about the rise in health care costs does not seem warranted. Yet, some strident critics persist in calling for a major overhaul in the health care delivery system—for more regulation and government enforced cost control.

We can answer such criticism by comparing the national health expenditures as a percentage of gross national product (GNP) among the Western nations (Table 2). Note that these data are only available from 1965 to 1980 and represent a shorter time interval. It is readily seen that growth in direct health care costs among these Western nations, in terms of their GNPs, is remarkably similar. Yet all countries, except the USA, have socialized health care systems in place. Note that the rate of increase for Great Britain, which has had socialized medicine based on a capitation system of reimbursement since the 1940s, experienced the same relative increase in health care costs as did the USA. Such comparisons demonstrate that socialization and greater government regulation do not limit health care expenditures as much as some policymakers believe.

Table 2.—National health expenditures in seven Western, industrialized countries, expressed as a percent of gross national product, 1965-1980. (Adapted from reference 1, table 2)

COUNTRY	YEAR 1965	1980	PERCENT INCREASE
Sweden	5.8	9.7	167
W. Germany	5.2	9.6	185
USA	6.1	9.4	154
France	5.9	8.9	150
Netherlands	5.0	8.9	178
Canada	6.1	7.4	121
United Kingdom	3.9	5.8	149

The costs of illness equals the cost of direct medical care plus the indirect costs of lost income. Rice, et. al., measured[2] both the direct and indirect costs for the 16 major diagnostic categories of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Their indirect costs were probably underestimated: indirect costs were defined as the value of lost output because of the cessation or reduction of productivity caused by morbidity or premature mortality. Morbidity costs are wages lost by people who are unable to work because of illness and disability and an imputed value for those persons too sick to perform their usual housekeeper services. Mortality costs are the present value of future earnings lost by people who die prematurely.

The results, calculated from Rice's data, are summarized in Table 3. The figures for direct costs are necessarily lower than the figures discussed above. The reason is that the authors examined only the 16 most common diagnostic categories of illness. The trends and conclusions are unaffected by this truncation. The data also covers the interval between 1963 and 1980. All the data have been recalculated in 1965 dollars.

Table 3.—Total, direct and indirect costs of illness i.e., cost of health care plus cost of lost wages, for the 16 major diagnostic categories of the ICD-9-CM, 1963-1980. All amounts are expressed in millions, and in inflation-adjusted, constant 1965 dollars. Adapted from reference 2, table 12.

YEAR	TOTAL COST	(% GNP)	DIRECT COST	(%)	INDIRECT COST	(%)
1963	95.939	(15.2)	23.118	(3.7)	72.821	(11.5)
1972	139.668	(15.9)	55.657	(6.3)	84.012	(9.6)
1980	159.023	(15.7)	80.729	(8.0)	78.294	(7.7)

In 1963 the total costs of illness for the 16 major diagnostic categories in the ICD-9-CM was $95.94 million (15.2% of the GNP). Direct costs, i.e., the cost of medical care, was $23.12 million (3.7% of the GNP) and indirect costs $72.82 million (11.5% of the GNP). By 1972 the figures for the total cost of disease were $139.67 million (15.9% of the GNP), $55.66 (6.3% of the GNP) for direct costs, and $84.01 million (9.6% of the GNP) for indirect costs. The 1980 total figure was $159.02 million (15.7% of the GNP), $80.73 million (8.0% of the GNP) for direct and $78.29 million (7.7% of the GNP) for indirect costs. Note that the total cost of disease, as a percentage of gross national product, was remarkably constant—between 15.2 and 15.9% of the GNP.[3] However the indirect economic costs of illness, as a percentage of the GNP, declined from 11.5% in 1963 to 7.7% in 1980. The savings in these indirect costs become more impressive when one factors in the population increase of nearly 20% between 1963 and 1980. When expressed per population member, indirect costs rose slightly from $35.87 in 1963 to $37.38 in 1972; from 1972 to 1980 per capita indirect costs of illness fell from $37.38 to $31.15! Thus medical care is engendering a significant decline in the economic burden of illness in terms of lost income. Note that these savings in indirect costs of illness are underestimated. They do not contain estimates of the costs of lost productivity or reduced efficiency of ill employees who remain on the job; they do not contain the lost income of family members who lose wages because of their need to stay home to care for a sick or disabled person. Of course, they totally neglect the value of improvement in the quality of life or the nonecomonic values of the significant extension of life expectancy that have accompanied the medical advances of the last 25 years.

Table 4 displays the total cost, per capita, of illness for the years 1963, 1972 and 1980 in constant, 1965 dollars. In 1963 the total per capita cost for illness was $486.02. This figure increased to $639.13 by 1972—a 3.08% compounded rate of increase. By 1980, however, the figure had risen very little—to $672.64—a compound rate of increase of less than one percent (0.6%). Thus the total cost of disease, per capita, was nearly stable from 1972 to 1980! The total cost of illness, when corrected for inflation and population increase is not increasing—contrary to the popular wisdom and pronouncements of the current time.

Table 4.—Rate of change in the cost of illness (health care costs + wage loss), 1963-1980. All dollar amounts expressed in constant, 1965 dollars.

YEAR	GNP (BIL)	POPULATION (MILL)	COST PER PERSON ($)	RATE OF CHANGE (%)
1963	633.3	197.4	486.02	—
1972	877.3	218.5	639.13	3.08
1980	1006.2	236.4	672.64	0.6

Thus, a more discerning inspection and collation of readily available and frequently cited statistics reveal that the cost of illness per citizen has been stabilizing over the past decade. The cost of medical care has increased but it has been rewarded by a corresponding drop in the lost wages that usually accompany illness. The increased cost in medical care has, therefore, not been economically detrimental to society. Furthermore the increased cost of medical care has paralleled a prolongation of life and an increased quality of life which have been additional, economically unmeasurable benefits of medical care.

Histrionic posturing, soul-wrenching doomsaying about the "crisis" in health care costs and cries for reform of the health care delivery system seem excessive and inappropriate after this analysis. Politicians and policymakers who heretofore have only examined one component of the cost of illness, viz, the cost of care, are committing the same error as the Chevalier de Mere: they are observing only a part of, but not seeing, the entire problem. Decisions based on defective vision can propagate great damage and lead to loss of furtune—as happened to de Mere.

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Daytona Beach

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGEONS

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FMA ANNUAL MEETING

Saturday, September 19—7:30 a.m. to 12:00 Noon

"Communications Skills"—Arch Lustberg

Educational Objective: To help the attendees improve their communication skills starting with the public.

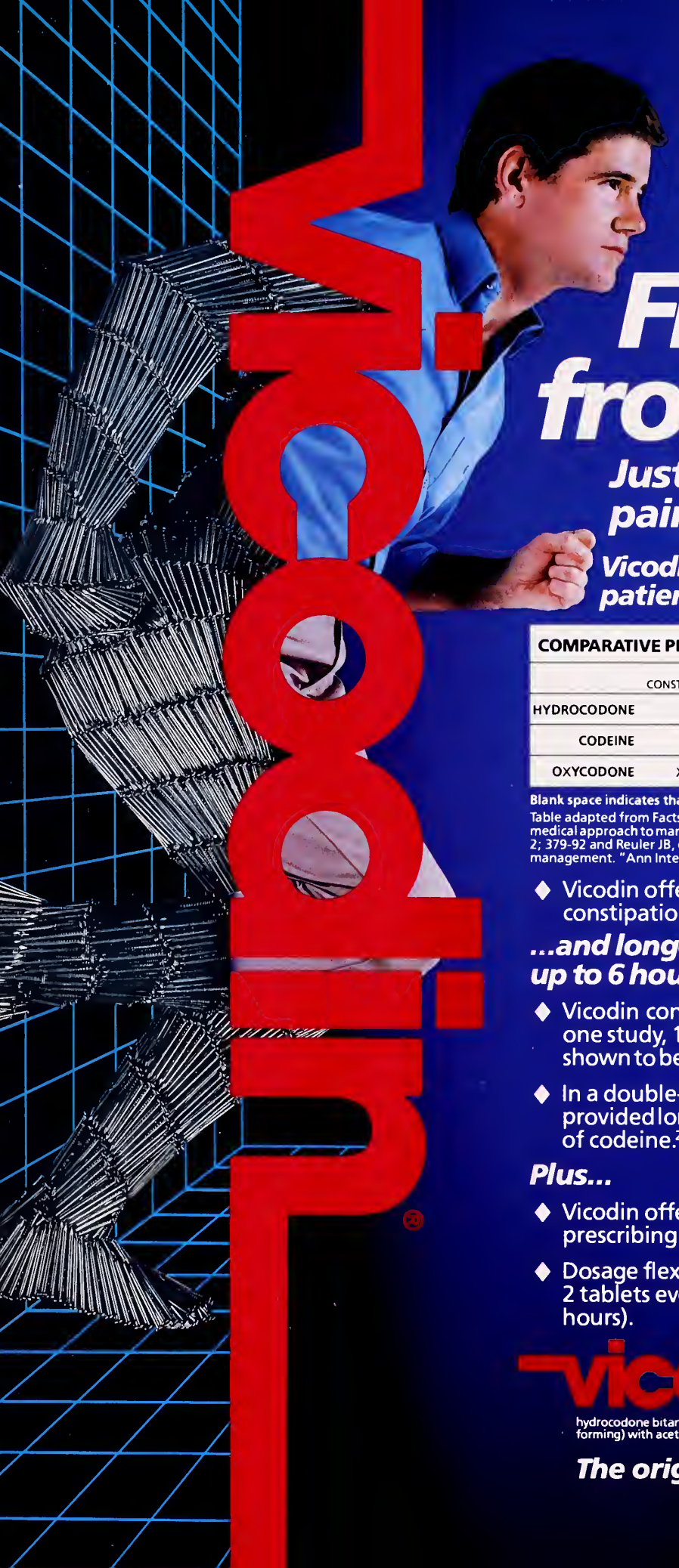
Business Meeting and Luncheon: Saturday, September 19—12:30 p.m. to 1:30 p.m.

THE FLORIDA ENDOCRINE SOCIETY PRESENTS:

The Section on Endocrinology
at the FMA Annual Meeting
Friday, September 18, 2:00 p.m. to 5:00 p.m.

Andy Taylor, M.D. *Associate Professor of Medicine*	Hirsutism
Michael Reeves, M.D. *Assistant Professor of Medicine*	Management of Type I & II Diabetes
Peter Livingston, M.D. *Associate Professor of Radiology*	MRI & Endocrine Disorders

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Freedom from pain

Just one part of pain relief therapy.

Vicodin® provides greater patient acceptance

COMPARATIVE PHARMACOLOGY OF THREE ANALGESICS

	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

- Vicodin offers: less nausea, less sedation, less constipation.

...and longer lasting pain relief– up to 6 hours.

- Vicodin contains hydrocodone not codeine. In one study, 10 mg. of hydrocodone alone was shown to be as effective as 60 mg. of codeine.[1]
- In a double-blind study, Vicodin (2 tablets), provided longer lasting pain relief than 60 mg. of codeine.[2]

Plus...

- Vicodin offers the convenience of CIII prescribing.
- Dosage flexibility–1 tablet every 6 hours or 2 tablets every 6 hours (up to 8 tablets in 24 hours).

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hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.

The original hydrocodone analgesic.

Specify "Dispense as written" for the original hydrocodone analgesic.



INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. S685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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J-6138 January 1986

News from DISTA about a new dosage form of cephalexin

ANNOUNCING NEW

Keflet™
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All the advantages of cephalexin in a convenient tablet form

- Backed by over 15 years of clinical experience
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- May enhance patient compliance, particularly among the elderly
- Tablet dosage form may be appreciated by patients of all ages

NEW Keflet Tablets are available as:

250-mg Tablets



500-mg Tablets

Keflet is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

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Brief Summary. Consult the package literature for prescribing information.
Indications and Usage: Keflet™ Tablets (cephalexin, Dista) are indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus pneumoniae* and group A β-hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflet is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflet in the subsequent prevention of rheumatic fever are not available at present.)

Otitis media due to *S pneumoniae, Haemophilus influenzae,* staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin-structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli, P mirabilis,* and *Klebsiella* sp

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose, the drug reached a maximum level of 4 μg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

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FLORIDA MEDICAL

DEPARTMENTS

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☐ 113th ANNUAL MEETING

Preliminary scientific program

The 113th Annual Meeting scientific program is being completed under the leadership of Pierre J. Bouis Jr., M.D., Chairman of the Council on Scientific Activities and Committee on Medical Education Chairman, Orris O. Rollie, M.D. Program highlights are listed below and as in the past, up to 15 hours of AMA Category I credit will be available to program registrants.

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy and Immunology Society)
Saturday, September 19, 1987—8:00 a.m. to 12:00 noon
Mark Stein, M.D., North Palm Beach
Program Chairman

Introduction—Michael Diamond, M.D., President, Daytona Beach
"Sinusitis, Nasal Polyps and Asthma"—Sheldon Spector, M.D., Clinical Professor of Medicine, UCLA, Los Angeles, California
"Environmental Control—What is Known to be Useful"— Harold S. Nelson, M.D., Clinical Professor of Medicine, University of Colorado School of Medicine
"Dust Mites of Tampa"—Enrique Fernandez-Caldas, Ph.D., Assistant Professor of Medicine, University of South Florida, Tampa
Asthma and Allergy Foundation of America, Florida Chapter Break
"Treatment of Status Asthmaticus 1987"—Harold S. Nelson, M.D.
"Asthma—When All Else Fails"—Sheldon Spector, M.D.
"Ventilator Support"—Michael Diamond, M.D.
Panel Discussion
Luncheon and Business Meeting

SECTION ON ANESTHESIOLOGY

(Co-Sponsored by Florida Society of Anesthesiologists, Inc.)
Friday, September 18—2:00 p.m. to 5:00 p.m.
Lawrence Berman, M.D., Gainesville
Program Chairman

"Perspectives in Risk Management in Anesthesiology"—Robert C. Covington, Vice President and Manager, Southeast Care Division, Alexander and Alexander, Atlanta, Georgia
Questions and Answers
Board of Directors Meeting
General Business Meeting

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Thoracic Society and Florida Chapter, American College of Chest Physicians)
Thursday, September 17—1:30 p.m. to 4:30 p.m.
Mark Snider, M.D., South Miami
David Solomon, M.D., Jacksonville
Martin Cohn, M.D., Miami
Program Co-Chairmen

Critical Care Medicine, Ethical Decisions and Risk Management Center—Martin A. Cohn, M.D., Moderator; Rabbi Solomon Schieff, Reverend Dr. McCartney and Jane Hendricks, Attorney, Bioethic Institute, St. Francis Hospital, Miami Beach, Charles L. Sprung, M.D., University of Miami School of Medicine, Miami, Panelists
"Determination of Death—Turning Off the Ventilator"
"Do Patients with Certain Diseases Abrogate the Right of Self-determination?"
"The Living Will—Must Is Always Be Honored?"
"Obtaining Informed Consent"

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)
Friday, September 18—1:30 p.m. to 5:30 p.m.
Saturday, September 19—8:30 a.m. to 12:00 Noon
Stephen Horwitz, M.D., Jacksonville
Program Chairman

"Cutaneous Signs of AIDS—Update '87"—Neal Penneys, M.D., Professor and Acting Chairman, Department of Dermatology and Cutaneous Surgery, University of Miami, Miami
Clinical Dermatopathology Conference—Richard J. Feinstein, M.D., Clinical Associate Professor, Department of Dermatology and Cutaneous Surgery, University of Miami, Miami
"Topical Psoralen Therapy of Alopecia Totalis"—Arthur Weissman, M.D., Associate Attending, Department of Dermatology, Mount Sinai Medical Center, Miami Beach
"Oral Hairy Leukoplakia II—Response to Anti-Viral Therapy" Jay Herbst, M.D., Resident, Dermatology, Mount Sinai Medical Center, Miami Beach
"Human Humoral Responses to Mosquito Bites"—Craig Leonardi, M.D., Resident, Dermatology and Cutaneous Surgery, University of Miami, Miami
"Human Adjuvant Disease"—Stephen J. Brozena, M.D., Chief Resident, Dermatology, University of South Florida, Tampa
Break
"Nail Cosmetics"—Richard Scher, M.D., Professor of Medicine, Brown University, Providence, Rhode Island
"Vasculitis and Endothelial Cells: New Concepts"—Thomas J. Lawley, M.D., Senior Investigator, Dermatology Branch, National Cancer Institute, NIH, Bethesda, Maryland

SECTION ON DIABETES

(Co-sponsored by American Diabetes Association, Florida Affiliate)
Friday, September 18—2:00 p.m. to 5:00 p.m.
Anthony Morrison, M.D., Tampa
Program Chairman

"Causes of Diabetes"—Anthony Morrison, M.D., Associate Professor, USF College of Medicine, Tampa
"Impotence and Diabetes"—Frederick Murray, M.D., Associate Professor of Medicine, University of Florida College of Medicine, Gainesville
Break
"Lipid Abnormalities in Diabetes"—Ronald Goldberg, M.D., Associate Professor of Medicine, University of Miami School of Medicine, Miami

SECTION ON FAMILY MEDICINE

(Co-sponsored by Florida Academy of Family Physicians and Pfizer Pharmaceuticals)
Friday, September 18—1:30 p.m. to 5:30 p.m.
Robert L. Dawson, M.D., St. Petersburg
Program Chairman

"New Concepts in Coronary Vascular Disease"—James F. Spann, M.D., Medical College of South Carolina, Charleston, South Carolina
"Lipids"—Mark Houston, M.D., Assistant Professor, Department of Internal Medicine and Co-Director, Medical Intensive Care Unit, Vanderbilt Medical Center, Nashville, Tennessee
"Management of Prostatic Disease: Guidelines for Primary Care Physicians"—Robert Rhamy, M.D., Veterans Administration Hospital, Miami
"Sports Medicine"—R. Stephen Lucie, M.D., North Florida Orthopaedic Center, Jacksonville

SECTION ON GASTROENTEROLOGY

(Co-sponsored by Florida Gastroenterologic Society)
Friday, September 18—2:00 p.m. to 5:00 p.m.
Patrick G. Brady, M.D., Tampa
Program Chairman

Introduction and Announcements—Patrick G. Brady, M.D., President
"Advances in Peptic Ulcer Disease Therapy"—Patrick G. Brady, M.D., Professor of Medicine, University of South Florida College of Medicine, Tampa
"Colon Carcinoma: Diagnosis, Therapy and Prevention"—Steve Goldschmid, M.D., Assistant Professor of Medicine, University of South Florida College of Medicine, Tampa
"The A, B, C and D's of Viral Hepatitis"—Allan Leibowitz, M.D., Associate Professor of Medicine, University of South Florida College of Medicine, Tampa
Break
"Medical Therapy of Gallstones"—Patrick G. Brady, M.D.
"Micronutrient Deficiencies and Assessment of Nutritional State"—Steve Goldschmid, M.D.
Panel Discussion

SECTION ON INTERNAL MEDICINE

(Co-sponsored by Florida Society of Internal Medicine and American College of Physicians)
Saturday, September 19—9:00 a.m. to 12:00 Noon
Wilbert Dawkins Sr., M.D., Jacksonville
Program Chairman

"Computerization of the Physician's Office"—Steven M. Zimmet, M.D., Chairman, Computer Services Committee, American Society of Internal Medicine; Mrs. Wendy Lewis, Independent Computer Consultant, Lakeland
Questions and Answers
Break
"Electronic Claims Processing"—Mr. Don MacCullum, Society Relations Manager, Medical Payment System (AMA), West Lake, Ohio; Mr. Churck Broes, District Manager, Wellcorp, Sparks, Nevada; Mr. Daniel G. Whitehead, Vice President, Marketing Provider Automated Services, Inc., Blue Cross/Blue Shield of Florida, Jacksonville

SECTION ON NEONATAL PERINATOLOGY

(Co-sponsored by Florida Society of Neonatal Perinatologists)
Thursday, September 17—1:00 p.m. to 3:00 p.m.
Jon W. Nagel, M.D., Pensacola
Program Chairman

"Current Status of Developmental Evaluation—Intervention Program for High Risk Infant and Preschool Children in the State of Florida"—Michael Resnick, M.D.
"Delivery Room Management of the Newborn—Recommendations Based Upon the Recent Changes in Pediatric Advanced Life Support (PALS) Guidelines"—David J. Burchfield, M.D.

SECTION ON NEUROSURGERY

(Co-sponsored by Florida Neurosurgical Society)
Saturday, September 19—7:30 a.m. to 12:00 Noon
Raul V. Rivet, M.D., Miami
Program Chairman

"Correlations of MRI with Other Diagnostic Testing in Spinal Disorders"—Judy Post, M.D.
"Evoked Potentials Monitoring During Neurosurgery"—Oscar Papazian, M.D.
Break
"Intraoperative Neurosonography"—Berta Montalvo, M.D.
Business Meeting

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)
Saturday, September 19—8:00 a.m. to 11:30 a.m.
Paul Gluck, M.D., Miami
Program Chairman

Resident Research Papers
"Anatomy of Pelvic Supports"—A. Cullen Richardson, M.D., Atlanta, Georgia

Break
"The Use of Hypnosis to Improve OB/GYN Care"—Larry Goldman, M.D., Vice President, Florida Society of Clinical Hypnosis, Ft. Myers
"An Anatomic Approach to the Surgical Treatment of Cystourethrocele"—A. Cullen Richardson, M.D.
Business Meeting

SECTION ON OCCUPATIONAL MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine, Florida Occupational Medical Association and Florida Chapter, American College of Emergency Physicians)
Thursday, September 17—1:00 p.m. to 4:00 p.m.
Nathan Grossman, M.D., Ocala
Program Chairman

Introduction—Nathan Grossman, M.D., Director, Marion County Public Health Unit, Ocala
"Preventive Aspects of Occupational Medicine"—Allen Koplin, M.D., Director, Hendry—Glades County Public Health Units. Former Director, Employee Health Service, New York City Department of Health
"Workers' Compensation Overview I"—Mr. Pat Wilson Parmer, Acting Director, Office of Medical Services, Florida Department of Labor, Division of Workers' Compensation
Break
"Workers' Compensation Overview II"—Ms. Nancy Rice, Consultant, Office of Medical Services, Florida Department of Labor, Division of Workers' Compensation
"Back Pain"—Brian Ellis, M.D., Chairman, Education Committee, Florida Chapter of the American College of Emergency Physicians, Melbourne
Presentation of the Joseph E. Baird Florida Occupational Medicine Association Award—Winning Medical Student Paper "Occupational Disease in the Commercial Printing Industry"—Raymond Lucas

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGEONS

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgeons)
Saturday, September 19—7:30 a.m. to 12:00 Noon
Mutaz B. Habal, M.D., Tampa
Program Chairman

"Communications Skills"—Arch Lustberg
Business Meeting and Luncheon

SECTION BY AMERICAN COLLEGE OF PHYSICIANS

(Co-sponsored by American College of Physicians)
Wednesday, September 16—1:00 p.m. to 5:00 p.m.
Panagiota Caralis, M.D., Miami
Program Chairman

"Cardiac Transplantation"—E. DeMarchena, M.D.
"Deep Vein Thrombophlebitis and Pulmonary Embolus: Approaches to Diagnosis and Therapy"—M. Gelbard, M.D.
"Evaluation of Lower Gastrointestinal Bleeding"—H. Manten, M.D.
"Management of Hypertensive Urgency and Crisis"—M. O'Connell, M.D.

SECTION ON CLINICAL ONCOLOGY

(Co-sponsored by Florida Society of Clinical Oncology and American Cancer Society, Florida Division, Inc.)
Saturday, September 19—9:30 a.m. to 12:00 Noon
Michael Harwin, M.D., Tampa
Program Chairman

"Treatable Poorly Differentciated Carcinomas of Unknown Primary Site"—John Hainsworth, M.D., Vanderbilt University, Nashville, Tennessee
"Carcinoid Tumors and Adrenal Tumors"—Robert Leeper, M.D., Memorial Cancer Center, New York
Break
"Childhood All-State of the Art"—Stuart R. Toledano, M.D., University of Miami School of Medicine, Miami
Question and Answer Panel
Business Meeting

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)
Saturday, September 19—9:00 a.m. to 12:00 Noon
Bascom Palmer Eye Institute
Harry W. Flynn Jr., M.D., West Palm Beach
Program Chairman

"Diabetic Macular Edema"—Harry W. Flynn Jr., M.D.
Discussion
"Techniques in Retinal Detachment Surgery"—David Kasner, M.D.
Discussion
"Strabismus Surgery"—Robert Lingua, M.D.
Discussion
"Common Eyelid Problems"—David Tse, M.D.
Discussion

DEAN'S MESSAGE

The cowboys and farmers can be friends

In the classic Broadway musical *Oklahoma*, one of the songs contains the line "The cowboys and the farmers can be friends." Many in the health care industry sometimes kiddingly say the same thing about the doctors and hospital administrators. Unquestionably, a study of the better academic health centers shows that their strength lies in the fact that the physicians and administrators have been able to get their act together. Over the past several years the University of Miami — Jackson Memorial Medical

Center has achieved an excellent reputation. This past year it was listed among America's 25 best hospitals. One of the major reasons for the Center's success has been the unselfish dedication of Jackson Memorial Hospital's Chief Executive Officer and President, Fred J. Cowell.

Shortly after he announced his intention to step down after 20 years at Jackson Memorial Hospital and ten as Chief Executive Officer, the *Miami Herald* published the following editorial entitled "The Public Servant:"

> "Rarely does any individual on the public payroll fit the title 'public servant' as well as Fred J. Cowell, the resigning executive of Dade County's Jackson Memorial Hospital (JMH). Mr. Cowell is the professional administrator who supervised the community effort that rescued JMH from disaccreditation and catapulted the facility just 10 years later onto the list of America's 25 best hospitals. JMH, which cares for both indigents and private patients, was the only publicly owned hospital on the list.
>
> At 47 Mr. Cowell is not ready to retire, though he does plan to take some time off before seeking a new position. Rather, he told the medical center's governing board the other day that he's simply ready for a change and that he believes that JMH can also benefit from his decision. For that reason he gave the Public Health Trust a generous six months' notice to select his successor.
>
> The selection team faces a formidable task. The medical center is a unique blend of functions. It treats both public and private patients. It's the teaching hospital for the University of Miami Medical School. It anchors the community's treatment of trauma, burns, paralysis, cancer, and other specialties. And it copes with a level of refugee patients unmatched in the nation.
>
> Through its decade-long, $100-million construction program and its continuous realigning of priorities and resources, JMH has been guided by the principle that Mr. Cowell emphasized in his remarks last week to both his staff and his bosses: a single high standard of medical care for all patients. That principle lifted JMH from the morass into which it had fallen in 1970, and that principle since has kept JMH out of the pejorative category where so many public facilities wallow. Jackson treats poor people, all right, thousands of them. But Fred Cowell was and is determined that there is no such thing under his responsibility as a 'charity' hospital: There are only good hospitals and bad ones, and he helped make JMH a superb one, for all its patients.
>
> There can be no finer legacy from a public employee than the commitment to a single, high standard of service for every person of whatever station who might need his agency's help. Mr. Cowell's tenure at JMH leaves that demanding example as testimony that excellence in government is possible when people care to get involved and make it work."

It is no secret that the University of Miami School of Medicine and its primary teaching hospital, Jackson Memorial Hospital, have among the nation's best relationships. Personally I take great pride in the fact that I can say that Fred Cowell is among the best friends I have ever had. During the past ten years we have had our differences. Both of us have responsibility to our respective institutions. Nevertheless, we never walked away from the table until we made a decision that was in the best interest of the Medical Center. I would also be remiss if I did not point out that Mr. Cowell's consistency to the noblest objective of the health care industry went far beyond the geography of the University of Miami — Jackson Memorial Medical Center. His contribution to the Hospital Cost Containment Board, the McKnight Committee, and a number of special governmental task forces has benefitted all citizens of our state. Everyone at our Medical Center will miss Fred Cowell. We wish him the very best and simply thank him for a job superbly done.

Bernard J. Fogel, M.D.
Vice President for Medical Affairs and Dean, School of Medicine, University of Miami

ENCORES!

Obstetriks in Amerika

My roots run back to a farm in South Georgia just outside a little town whose name most people cannot pronounce. My childhood was blessed with happy memories of lazy summer days spent fishing for bream down at the pond and of Sunday dinners with all the aunts, uncles, cousins, and grandparents sitting around my grandmother's table enjoined in a feast of food and family celebration. It was my grandmother who probably unknowingly influenced me to go into medicine. I spent many of my childhood hours rocking along side her on her front porch, talking about worldly matters, and listening to the vivid tales she could tell about her life. She was truly a genteel woman; softspoken, proud and loved a good joke. She loved to tell me about her "churin", my aunts, uncles, and especially my father.

My father was the only one to stay on to run the farm. The others became a homemaker, an automobile dealer, a dentist, and a doctor. I remember sensing a glow of pride in her voice when she talked about her youngest, my uncle Bob, who went off to Emory in Atlanta to become a DOCTOR.

She also was quick to remind me that he was not the only physician to sprout from the dusty roads of our little community. The Hatcher's boy, Charlie, had gone up to Emory too and was interested in cardiovascular surgery. The local G.P., Doctor Welch, had a son, Carl Junior, who would one day become a psychoanalyst, and the Jackson's boy, Royce, was going into psychiatry too. And then there was this boy, Orson Smith, raised right down the road in a settlement named Benjin who had been in medical school with uncle Bob. Before she knew it the seed was planted. The image of "Physician" became firmly equated to "respect," "sacrifice," "service to mankind," and "humility."

As might be expected I went on to play the lead in the senior class production of "Big Doc's Girls" and received Best Actor award (was I really *acting*?). Naturally, when college time rolled around I hurled myself into the path of the Pre-Med curriculum without the faintest idea of what actually lay ahead. Two years later I got serious and with a stroke of luck found myself heading to the Medical College in Augusta, Georgia, in the fall of 1968. I was absolutely stunned that I got admitted. And I was equally stunned that some of my classmates got admitted. So began my early understanding of the balances in nature.

I will never forget the first time I witnessed a birth on my OB rotation in the Winter of 1970. Little did I realize that this one would soon pale in the light of my son's arrival in March of the same year. I knew almost immediately that OB was what I wanted to do with my life. It combined the best of all worlds; obstetrics, surgery, and medicine all wrapped up in packages of healthy, motivated patients called females (the only limitation of the specialty).

I was engulfed by the romance of it all. The responsibility of watching over the growth and development, and ultimately, the entry of a human life into the world was overwhelming. The chance to play the lead in this play was just too much to pass up.

The "Georgia boy" soon found himself on stage in Gatorland, U.S.A.—Gainesville, Florida, for a residency in OB-GYN. The romance continued, and every passing day brought forth fruits of knowledge, and newly acquired skills. The thirst for independence grew, and was at last quenched at the well of the Chief Resident. Finally I could call the shots, and make decisions with the tools I had struggled so hard to master. It felt good.

I didn't quite realize how easy it was to feel "good" within the walls of the medical Mecca until a few months later when I was stranded on Guam in the midst of the vast Pacific. "That's O.K.," I said. "What better place to get your feet wet." Uncle Sam was picking up the liability insurance tab, hiring, firing, and managing the personnel, paying for all supplies, giving paid vacations, and paying peanuts in return . . . but at least nobody questioned your indications for surgery because whether you did one or one hundred, your paycheck was the same. This little peach turned sour about the time I was nearly transferred to a spy ship off the Russian coast. Common sense dictated that I should wrap things up and head back to the panhandle.

In July of 1979 the sharp realities (and rewards) of private practice smacked me in the face like a blast of arctic air. Here I could palpate the whole ball of wax. Not only could I call all the medical shots on my own, but I could also bear the consequences of my business and management blunders as well. It was a learning experience but carrying me through it all was the satisfaction of giving my patients the kind of care I felt they deserved in the fashion that I wanted to deliver it. The romance lived on. I was still moved at the well of tears in a new mother's eyes when she first heard the beat of the baby's heart, or the well of tears in a new father's eyes when he first heard the cry of his baby's voice. Life was full of the rich rewards of obstetrics and the final realization of what it meant to be called "Doctor" in the way that my grandmother meant it. By age five the dream was terminally ill.

Something ugly and foreign to my spirit invaded the world I had so briefly known. The three short years ahead would reshape my image of "physician" and perhaps redefine the word itself. A new vocabulary was born with words like "gatekeeper, vendor, HMO, PPO, DRG, PRO, U.R. nurse, and pre-admission certification" to name a few. Each new entity would strip me of one more facet of the child-like freedom with which I had practiced medicine over the past 12 years. And in the wake of this restructuring I would witness physicians struggling to survive the competition by prostituting themselves, and dishonestly playing the system. I also witnessed the birth of a physician-owned HMO groping to preserve the last bastion of control over patient care.

For the next three Decembers I would stare in disbelief at my soaring liability insurance premiums, and my stagnant, discounted reimbursement from prepaid health plans. I would be confounded by the impotency of our legislature to enact a remedy for a system truly run amuck. A system in which I felt hostage to the legal profession, and paranoid about literally every professional move I made.

The doctor-patient relationship would erode into an ulcer dressed with voluminous chart notes, redundant and often unnecessary lab tests, and reams of consent forms rivaling the legalese of government contracts. My actions would soon take on a pattern of logic in this order: Could I be sued for this? Has

this been approved by the Plan or the PRO? Will this pass Utilization Review? What do I feel is best?

Like so many obstetricians I feel that I have so much I want to give, yet it becomes increasingly difficult to give it these days. The ranks of obstetricians continue to shrink as more of us relinquish our love of the profession and our freedom to practice it as we see fit. Perhaps it will take the evolution of a new breed of obstetricians specifically adapted to practice Obstetriks in Amerika!

My roots run back to a farm in South Georgia . . .

John Taylor, M.D.
Tallahassee

Reprinted with permissino from *cap scan*, Capital Medical Society, July 1987, pp. 1, 2.

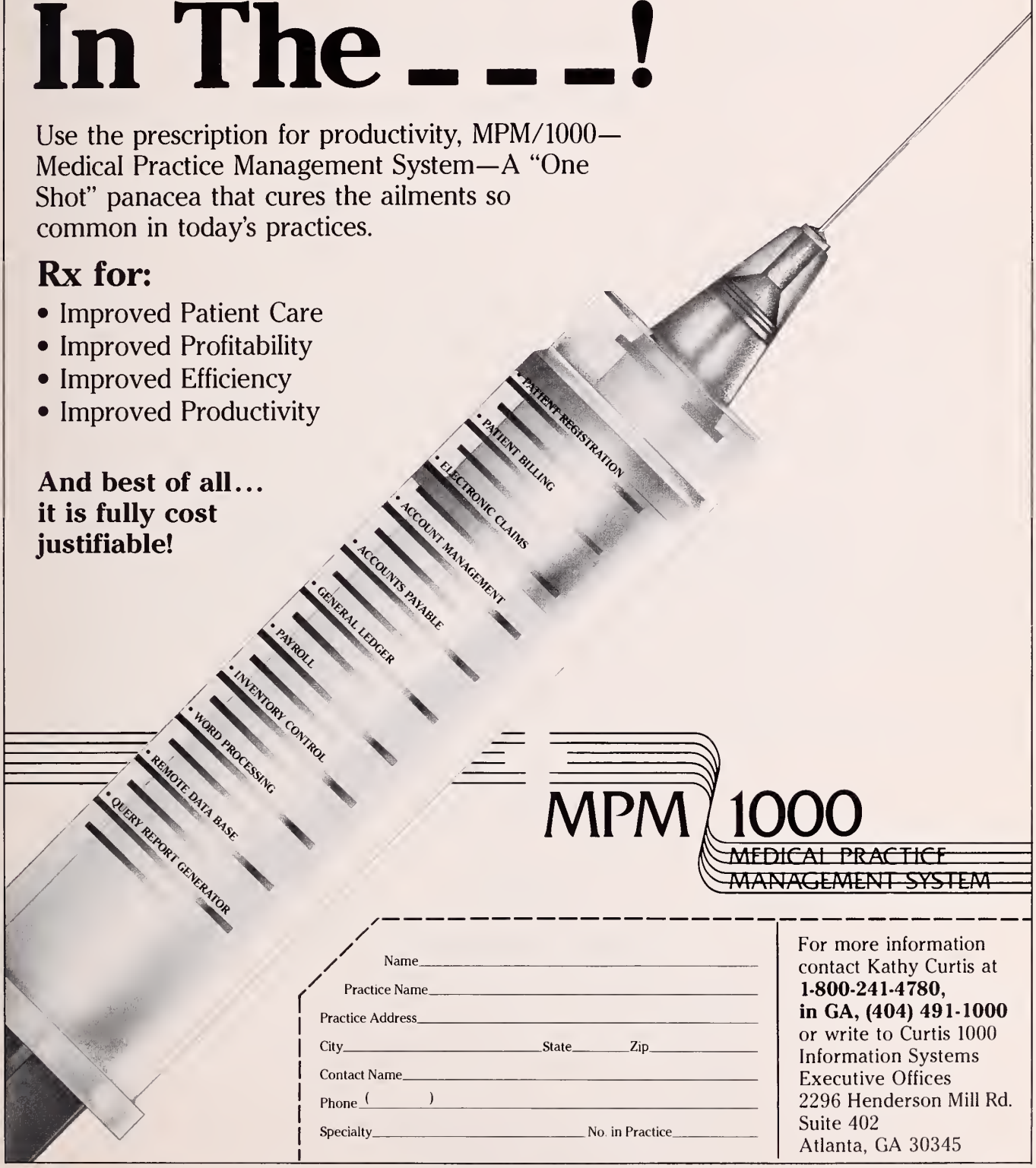
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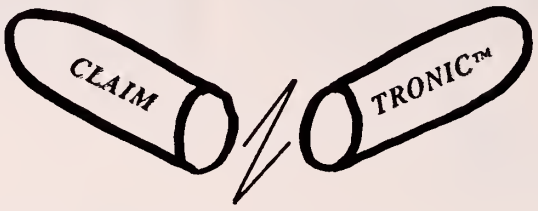
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Vitamins and Minerals: Help or Harm?

by Charles W. Marshall, Ph.D. 237 pages, price: $10.95. George F. Stickley Company, Philadelphia.

The days when one could practice good medicine with only a vague notion of nutrition are past. The deluge of books, magazines, tabloid articles, and television talk shows giving out incomplete or frankly misleading information on the subject has turned the American public into a mass of misinformed experts. Our patients are encouraged to challenge their doctor with this misinformation by the very charlatans promoting it, for most of us lack the store of facts needed to meet this challenge convincingly.

Charles Marshall, Ph.D., first published this review of the subject of vitamins and minerals in nutrition in hard cover edition in 1983. In the current softcover republication, he has revised and updated the information. The book brings together a very comprehensive review of the subject obtained in consultation with a long and impressive list of many of the outstanding biochemists and nutritionists of America. It is written for the lay public but referenced and footnoted enough to satisfy the most scientific reader.

Dr. Marshall begins his introduction with the statement: "The purpose of this book is to discourage you from taking extra vitamins and minerals — especially large doses — if you don't need them." He first discusses vitamin quackery in general, then the benefits and possible harm of taking each of the vitamins and major minerals in subsequent chapters. He discusses many of the popular myths about vitamin therapy directly and specifically — quoting proponents and giving the evidence against them. He then concludes with general recommendations for sensible nutrition.

Many physicians will find it worth their while to sit down and read this book through, as a short refresher course in nutrition. Nearly all of us would be wise to have such a book in our library for ready reference — to fall back on when challenged by patients who are being bombarded with less reliable information.

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Auxiliary Liason Editor—Mrs. Walter (Isabella) Laude

Support group formation on a local level: Palm Beach County's response to medical malpractice crunch

Malpractice litigation may stem from various roots. However, whether the reason is justified or unjustified for our physicians of today, the possibility of being sued is indeed a reality. In the 1970s, claims continued to increase and liability insurance became more difficult to obtain. Today, the problem has reached crisis proportions as we evidence daily upon opening our papers or tuning in the television news. The intent of this article is not to explore why the problem has increased, nor to delve into such a complex issue, nor its resolution. Rather, to offer suggestions how we as Auxilians and physicians can help one another to cope with such a personally and professionally devastating experience.

We, as physician spouses, share insight into the special circumstances of the joys and sorrows of being part of a medical family. We enjoy a common bond that leads to the realization that we alone can offer true understanding and support to our peer group. There is no place to hide from this responsibility. The personal and professional health of our medical community and our common determination to enhance the quality of life of our families, our communities, and our country demand our attention. Both on a national level through our AMA-A and on a state level through Susan Marks, our FMA-A President, the urgent cry to form support groups on a local level is clearly heard.

We, in the Palm Beach County Auxiliary, have attempted to follow this lead and have formed a small support group this year. Although we have a feeble beginning, the seeds have been planted and we are working on cultivating them and researching future options. After selecting a Chairperson for our group, we spread the word through our Auxiliary newsletter, *The Pulse*, and our monthly medical society journal, *On Call*. A local reporter picked up the scent and interviewed two of our members during lunch. This we shared very ambivalent feelings about, but found we did receive many interesting comments from members of our community upon its printing. As you might expect, they varied from very concerned and encouraging remarks to very angry, hostile admonitions.

To further increase awareness among our members, our countywide January meeting was held at the home of one of our members, and presented the shocking headlines, "One In Four Doctors' Wives Will Be Affected By The Malpractice Syndrome." Our program promised an intimate peek at "Is There Life After the Medical Malpractice Experience," and "The Problem Patient." This thought-provoking session detailed the experiences of our peers who have survived this situation. This stimulated a very personal sharing among our members who had been through this wrenching experience (of which there were many present). A very special aura took place in the room and a strong awareness of that very personal bond that draws us together as physicians' spouses took over. Comments and calls were received for days as many of our members were awakened to a current Auxiliary. Additional volunteers were gathered to help with our fledgling committee.

Phone calls have been made to several of our "fellow auxilians and spouses" who were on the threshold of malpractice litigation. We offered a variety of services including carpool help, casserole preparation and delivery, and whether the presence of our members in the courtroom would be welcome or uncomfortable. The latter offer was a physical show of support that some physicians and situations welcome and others preferred not to take. I understand in some communities in our state much success has been felt attributed to this type of support. Our response was limited, but one response was universal

—that of gratitude for the call. In some cases, the physicians' spouse may want to contact a committee member at a later date though refusing help intially. It appears to be a great need to those going through this trauma to have someone to listen to just how they feel. Remember, it is not just the physician who feels the impact of this shattering experience, the spouse and the children also share the trauma, anger, frustration, etc. The accusation itself must be lived with—even if the case is dropped. All family members fear the loss of public image, prestige in the medical community, and financial security.

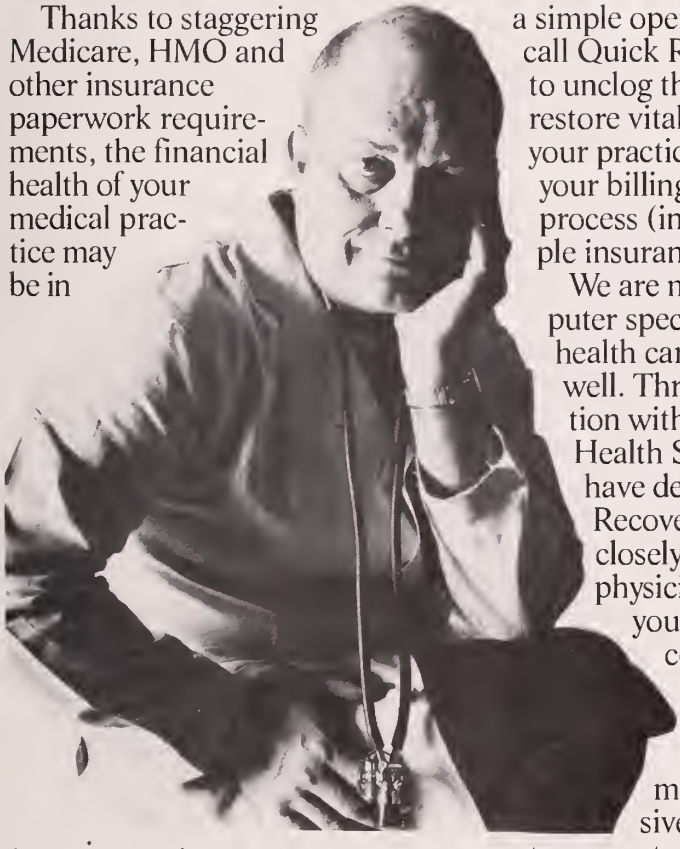
Rather than rely on newspaper headlines and "word of mouth" to obtain news of malpractice litigation, we have discovered the *Palm Beach Review*, a local daily business and law newspaper. It comprises a section of court information listing suits including names of those involved. However, "M.D." is frequently omitted so names in a large county are easily missed, and it is not all-inclusive. It is not the complete answer, nor is sitting in the County Clerk's Office and sifting through suits filed. However, it may be an alternative method.

At present, our support group also responds to illness, death, or other situations as well as malpractice, as an extension of our Friendship Committee. Recently, our Auxiliary has also been contacted by our Palm Beach County Medical Society through the Impaired Physicians Committee to help them in regards to development of physician support services. This would be a referral service to help physicians and their families who are in acute stressful situations such as malpractice trials, divorce, family death, child abuse, drug and/or alcohol abuse. This Medical Family Support Network is also in the formative stages, but has already proven invaluable. The Auxiliary has been asked to befriend and offer support in those situations where it may be required. All contacts are confidential. At this time, the Auxiliary has recruited enough volunteers so that a one-day training workshop is being set up by the Medical Society to provide the necessary background to deal with these situations. If counselling is indicated, the Auxilian will refer the situation to the Medical Society Committee as established. Presently, it is thought that these two committees will function on somewhat different levels; however, it may behoove us to combine them into one unit.

As you can see, we have merely tipped the fringe of our resources. We have much more cultivating to do before we reap the rewards of a smoothly working organization able to benefit our peers. There are many avenues to pursue in offering further reassurance of available support: booklets, guest speakers, discussions, panels of physicians, etc. However we have established a seedling crop and until the climate exists where our physicians can provide high quality medical care without fearing undue litigation and in which actual victims of negligence can receive fair compensation, we must band together to offer support to one another through this crisis. We alone can uniquely identify with the stress, trauma, and pain of our peers—we alone can be by their side sharing a true understanding of the anger and frustration—we alone can help!

Mrs. Tom (Carolyn) Coffman
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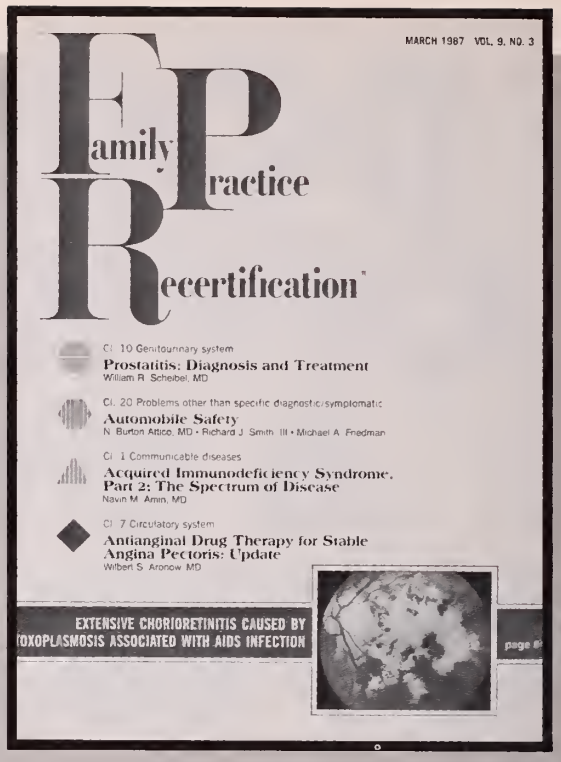
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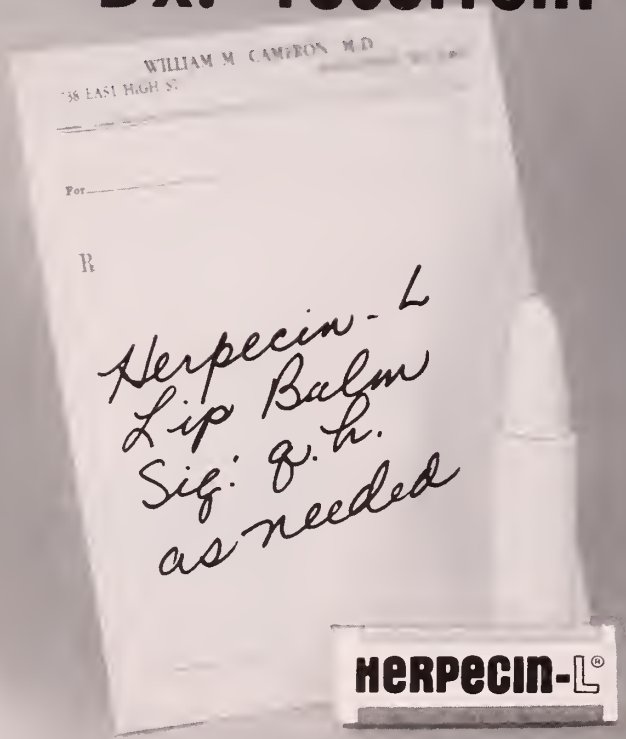
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Doppler Echocardiography Seminar, September 10-12, Innisbrook Resort Conference Center, Tarpon Springs. Contact: Registrar, Ultrasound Center, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, N.C. 27103 or call (919) 748-4505.

Magnetic Resonance Imaging: A Technologist's New World, September 10-12, Peabody Hotel, Orlando. Contact: Martin Silbigu, M.D., (813) 974-2538.

Medical Risk Management, September 12, TBA, St. Pete. Contact: Ronna Davis, P.O. Box 12099, Tallahassee, FL 32317 or phone (904) 385-4935.

Clinical Update—Health Behavior and Disease, September 12, Tampa Marriott Westshore, Tampa. Contact: R.M. Bhatty, M.D., (813) 237-3914.

Fractures of the Pelvis and Acetabulum, September 12-19, Paris, France. Contact: Emile Letournel, M.D., (813) 974-3322.

Medical Malpractice, Prevention & Defenses, September 15-16, Miami Beach. Contact: Mt. Sinai Medical Center, Attn: CME Coordinator, 4300 Alton Rd., Miami Beach, FL 33140. (305) 674-2311.

FMA Annual Meeting Scientific Program, September 16-20, Diplomat Hotel, Hollywood. Contact: Robert Fore, Ed.D., 760 Riverside Avenue, Jacksonville, FL 32204, (904) 356-1571.

Head & Spinal Cord Injury, September 17-18, Pensacola. Contact: Phyllis Connerley, (904) 478-4460 ext. 4178.

Pediatrics for the Practitioner, September 18, Sheraton Tampa East, Tampa. Contact: H. Pomerance, M.D., (813) 974-4214.

Comprehensive Course in Small Incision Phacoemulsification Cataract Surgery, September 18-19, Indigo Lake Resort, Daytona Beach. Contact: Albert Neumann, M.D., (904) 734-4431.

Current Concepts in the Diagnosis and Management of Adult Heart Disease, September 18-19, New World Landing, Pensacola. Contact: (904) 478-4460.

Urology for the Non-Urologist, September 19, Jacksonville Marriott, Jacksonville. Contact: Marie Tyne (904) 355-6583.

ACLS Provider Course, September 26-27, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D., (813) 251-6911.

OCTOBER

The Friary's Sixth Annual Professional & Chemical Dependency Seminar, October 2, Pensacola Beach. Contact: Brunie Emmanuel, (904) 932-9375.

Emerging Trends in Critical Care—1987, October 7-9, Crowne Plaza Hotel, Orlando. Contact: Rick Mace, (305) 897-1575.

Medical Risk Management, TBA, Miami. Contact: Ronna Davis, P.O. 12099, Tallahassee, FL 32317. (904) 385-4935.

Cardiopulmonary Update, October 9-11, Marriott at Sawgrass, Ponte Vedra Beach. Contact: Alberta Hipps, 1800 Barrs St., Jacksonville 32203. (904) 387-7563.

All America's Health '87, October 15-18, Curtis Hixon Convention Center, USF College of Medicine. Contact: P.J. Bouis Jr., M.D. (813) 974-4296.

International Symposium on Gynecologic Oncology, Surgery and Urology, October 18-23, Japan. Contact: Patti Mundy, (305) 549-6944.

Thirteenth Annual Panamerican Seminar, October 19-23, Mt. Sinai Medical Center, Miami Beach. Contact: Mt. Sinai Medical Center, Attn: CME Coordinator, 4300 Alton Road, Miami Beach 33140. (305) 674-2311.

Magnetic Resonance Imaging, October 19-23, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

Fall 1987 Familly Practice Review, October 19-23, Peabody Hotel, Orlando. Contact: Grace Wagner, JHMHC J-233, Gainesville 32610. (904) 392-4321.

A Case Study Approack to Risk Management and Malpractice, October 23, Sheraton, Bal Harbour. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

Thirteenth Annual Gulf Coast Internal Medicine Conference, October 23-24, Pensacola Hilton, Pensacola. Contact: Dr. Garth Grove at (904) 474-7101.

Twenty-eighth Workshop in Electrocardiography, October 28-31, Sheraton Sand Key, Clearwater Beach. Contact: Henry Marriott, M.D., (813) 894-0790.

Fifth Annual Advanced Neuroradiology, October 29-31, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, (813) 974-2538.

A Case Study Approach to Risk Management and Malpractice, October 31, Contemporary Hotel in Walt Disney World. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

Medical Risk Management, TBA, Tampa. Contact: Ronna Davis, P.O. Box 12099, Tallahassee, FL 32317. (904) 385-4935.

NOVEMBER

Primary Care Update: Seventy-second Scientific Assembly, November 2-5, Diplomat Hotel, Hollywood. Contact: Ray W. Gifor Jr., M.D., (608) 257-6781.

Thirteenth Annual Obstetrics and Gynecology Review Course, November 3-11, Doral Hotel on the Ocean, Miami. Contact: Patti Mundy. (305) 549-6944.

Advanced Applied Ultrasound in Obstetrics, November 5-7, Bowman Gray School of Medicine, Naples. Contact: Regsitrar, Ultrasound Center, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, N.C. 27103 or call: (919) 748-4504.

Neonatal & Pediatric Respiratory Disease Conference, Sheraton Sand Key, Clearwater Beach. Contact: R. Lawrence Siegel, M.D. (813) 972-3131.

ACLS Provider Course, November 7-8, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

American Heart Association ACLS Instructor Course, November 7-8, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

Thirteenth Annual Ob/Gyn Pathology Review, November 12-15, Doral Hotel on the Ocean, Miami. Contact: Patti Mundy (305) 549-6944.

Nutrition in Pediatric Practice, November 13, Sheraton Tampa East, Tampa. Contact: Herbert Pomerance, M.D., USF Dept. of Pediatrics, 12901 Bruce B. Downs Blvd., Box 15Ce, Tampa, FL 33612. (813) 974-4214.

The Distal Radioulnar Joint, November 13-14, Orlando. Contact: Paula Scheid, 3025 S. Parker Rd., Suite 65, Aurora, CO 80014. (303) 755-4588.

Flexible Sigmoidoscopy, November 14-15, Sonesta Beach Hotel, Key Biscayne. Contact: John P. Christie, M.D., (305) 687-1367.

All America's Health '87, November 15-18, Curtis Hixon Convention Center, Tampa. Contact: Pierre J. Bouis Jr. M.D., (813) 974-4296.

Eleventh Annual Seminar of the Florida Association of Pediatric Tumors, November 19-21, Holiday Inn Crown Plaza, Orlando. Contact: Cindi Butson, P.O. Box 13372, University States, Gainesville, FL 32604. (904) 375-6848.

ACLS Provider Course, November 28-29, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

DECEMBER

Clinical Allergy & Immunology for the Practicing Physician, December 3-5, Buena Vista Palace, Lake Buena Vista. Contact: Richard F. Lockey, M.D., (813) 972-7631.

1987 Neuro-Opthalmology Course, December 3-5, Key Biscayne Hotel, Key Biscayne. Contact: Goby Kressly (305) 326-6031.

The Journal of the Florida Medical Association, Inc.

Classified Advertising Form

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PHYSICIANS WANTED

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

FAMILY PRACTICE OPPORTUNITY: Share in a rapidly expanding practice on the Gulf Coast Sarasota/Bradenton. X-ray and laboratory on-site. Adjacent to HCA Hospital. Built in referrals. Share call nights, weekends, and holidays with physicians. Reply P.O. Box 14744, Bradenton, FL 34280.

FAMILY PRACTICE — Opportunity to join 3 board certified FPs in a rapidly growing practice at the beach. Excellent community to live and grow next to a large metro area. Practice is strong in wellness preventive and psychosocial medicine. Salary negotiable with opportunity to buy in. Contact North Beaches Family Practice, 100 Royal Palm Drive, Atlantic Beach, FL 32233, (904) 241-5107.

ORLANDO: Full-time opportunities available for physicians board prepared in Family Practice, Internal Medicine or Emergency Medicine to staff a new Urgi-Care facility in the Orlando area. Excellent compensation plus malpractice insurance provided. Respond with CV to: Cheree Richards, EMSA, 100 N.W. 70th Ave., Plantation, FL 33317 or call collect at (305) 584-1000.

SUNBELT OPPORTUNITIES: Florida, Georgia, Alabama. Available now for BC/BE physicians or general practitioners (central Georgia). Completely confidential. Please respond by sending CV or Telephone: Frank B. Lane, M.D., Medical Director, Medical Consultants of America, 5121 Ehrlich Rd., Suite 107A, Tampa, FL 33624. (813) 968-3878.

ACTIVE, ESTABLISHED AMBULATORY CARE CENTER seeking Board Certified Family Practice or Emergency Physician for full-time work. Excellent community. Diverse outdoor recreation, excellent schools and housing values. Superior working environment-no night call. Class "A" malpractice category in "low-risk" area of Florida. 48 hours/week $103,000. Please contact: Douglas Sherman, M.D. or Bill Riddle at Physician Care (904) 386-2266.

STAFF PSYCHIATRIST: Exciting opportunity for Florida-licensed, board eligible or certified psychiatrist interested in quality psychiatric services with child/adolescent experience, to work full or part-time in comprehensive JCAH-accredited mental health center and psychiatric hospital. Primary duties include direct inpatient care with oportunities for variety of outpatient services, academic affiliation, and outside income. Competitive salary. Please send resume to Guillermo Dardano, M.D., Medical Director, Northside Centers, Inc. 13301 N. 30th St., Tampa, FL 33612. (813) 977-8700.

PEDIATRICIAN-CENTRAL FLORIDA: Established BC pediatricians in four-man practice seeking BC/BE Pediatrician Associate. First two years' salary and productivity bonus leading to partnership. Send CV and Resume of Medical/Pediatric Experience to: Joe Stansell and Associates, P.O. Box 40543, Jacksonville, FL 32203-0453.

ALL SPECIALTIES NATIONWIDE: Ready for a change? MPA has highly skilled Recruiters who can match you with the opportunity you have been seeking. Solo, group and partnerships available. Send CV or call Medical Recruiters of America, Inc., 7771 W. Oakland Park Blvd., #200, Ft. Lauderdale, FL 33321. Toll Free: (800) 327-2759; toll-free in FL: (800) 423-3191.

BC/BE OB/GYN needed for Colquitt Regional Medical Center in Moultrie, DA to replace retiring OB/GYN physician. Guaranteed package and highly competitive. In an average year we deliver 520 babies and do 282 GYN surgeries. Contact: Dr. Norman Reese (912) 985-3420 ext. 357.

DAYTONA: Full-time opportunities available for board prepared emergency physicians in this 200-bed hospital. Beautiful Daytona Beach speaks for itself. For further information contact: Cheree Richards, EMSA, 100 N.W. 70th Ave., Plantation, FL 33317 or call collect at: (305) 584-1000.

SOUTH EAST FLORIDA: Well-established, high volume walk-in centers looking for U.S. med school graduates with extensive E.D. experience. Career positions available with opportunities for management, equity, and incentive participation. Malpractice and health insurance provided. Send resume to: North Federal Management Group, 639 N. Federal Highway, Pompano Beach, FL 33062.

PSYCHIATRIST: Excellent opportunity for board certified or eligible psychiatrist. This position provides the advantage of being able to establish a vital practice with minimal inital investment. Broad range of fee-for-service delivery within well-established referral network serving lovely waterfront communities. Reply to P.O. Box 2068, Cape Coral, FL 33904 or call (813) 772-9099.

UNIQUE OPPORTUNITY FOR PHYSICIANS: Private practice of your specialty (exclusives given). Ocean Medicine Center. Since 1969, serving affluent population of 40,000 in Galt Ocean Mile/Adjoining Beach Area. Urgently needed: Cardiologist, Derm., ENT, G.I., Neuro., Ortho., Plastic S., Pul. and Rheum. No salary, but will help with office rent. Call collect (305) 776-5800. Ocean Medical Center, 4001 Ocean Dr., Lauderdale-by-the-Sea, FL 33308. FL license mandatory.

CARDIOLOGIST: BE/BC, excellent opportunity with outstanding potential. Modern progressive hospital in an ideal southern family community. Write: Box C-1393, P.O. Box 2411, Jacksonville, FL 32203.

DIRECTOR PHYSICAL MEDICINE AND REHABILITATION: 21 bed in-house unit at 500$ bed major medical center on SE Florida coast. Metro amenities, excellent housing, schools and universities. Directorship, marketing experience a plus. 2 year guarantee plus stipend, relocation, overhead. Contact Sandy. Tyler & Co., 9040 Roswell Rd., Atlanta, GA 30338 or call collect: (404) 641-6411.

FAMILY PRACTITIONER INTERNIST: preferably certified. Some clinical experience preferred. New Port Charlotte location. No starting up costs. Opportunity to grow with group dedicated to providing complete medical care. Available July 1987. Contact: S.P. Silverblatt, M.D., 616 Atlantic Shores Blvd., Suites D & E. Hallandale, FL 33009.

DIAGNOSTIC RADIOLOGIST: Locum Tenens work available immediately. Full year or long long-term intervals. High compensation and liberal vacation time. Write Box C-1399, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PHYSICIAN: BC or BE for West Palm Beach practice. FL license necessary. Opportunity for future partnership. Call: (305) 967-0234.

TIRED OF HMOs? Conduct your specialty or primary care practice in a traditional setting in a growing community south of Ocala. Demand for all specialties exceeds supply (AMA market profile available). The new Mockingbird Hill Professional Center is now open with lease/purchase option. Opportunity now exists for custom interior design. Lab and x-ray on-site and private ambulatory care center provides a referral base. Only 10 min. drive to HCA hospital. For information call or write Carol Roberts, Care-1, Inc., 1805 S.E. Lake Weir Ave., Ocala, FL 32671 or (904) 351-0789.

WANTED: PEDIATRICIAN to join a young but busy solo private practice in pretty community near Disney World and Beaches. Excellent Regional Hospital. Send CV to Box C-1402, P.O. Box 2411, Jacksonville, FL 32203.

BOARD CERTIFIED GENERAL SURGEON, as associate, private practice in Orlando. Send CV, references, photo to Box C-1366, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTITIONER - CENTRAL FLORIDA: Position available in Central Florida for a residency trained, Board eligible or certified Family Practitioner, to join our 4 other FPs in a 30-man multispecialty group. Excellent starting salary with benefits. Please send CV with picture to G. J. Rafool, M.D., Gessler Clinic, 635 1st St., North, Winter Haven, FL 33881.

GENERAL MEDICINE—Primarily internal medicine, family practice and geriatrics. Part-time associate wanted. can lead to full-time position if desired. No night call or weekends. Located in Largo, FL., 2 miles from Gulf beaches. Salary negotiable. Perfect position for semi-retired physician or physician starting practice. Contact: R. Chris Brown, M.D., 1890 W. Bay Drive., Largo, FL 34640. (813) 585-5190.

OB/GYN, ORTHOPEDIC surgery, family practice, internal medicine opportunities. Bernie Hoffmann Associates, Inc., a Nationwide Health Care Consulting Firm, is currently assisting major midwest health care providers in their search for physicians in the aforementioned specialties as well as others. All opportunities offer paid malpractice, attractive income guarantees with incentives and comprehensive fringe benfit packages. All inquiries will be handled in the strictest confidence. Please forward c.v. or call Damian Kozak or John Rafferty, Bernie Hoffmann Associates, Inc., 20755 Greenfield, Suite 601, Southfield, MI 48075. (313) 557-9340.

INTERNIST OR FAMILY PRACTITIONER BE or BC to join busy solo practitioner 10 miles north of Clearwater. Salary plus benefits. Please send CV to Physician. P.O. Box 1614, Palm Harbor, FL 33563.

FLORIDA LICENSED physician for Family practice activities. Public Health background helpful. Reply: Collier County Health Dept., Director's Office, P.O. Box 428, Naples, FL 33939. (813) 774-8210.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

DIRECTOR OF ANESTHESIA: 518-bed, teaching hospital with large OB/trauma service on Gulf in West Central Florida with outdoor, cultural activities; good schools/housing. Board certified with strong clinical, organizational, and supervisory skills. Fee-for-service with stipend, relocation. Contact: Mary, TYLER & CO., 9040 Roswell Rd., Atlanta, GA 30338. Collect: (404) 641-6411.

B/C or B/E INTERNIST wanted for busy, established in practice in beautiful resort community on Florida's west central coast. Opening immediately available. Financial renumeration negotiable. Unique opportunity for the right individual. Respond to: Box C-1412, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE PHYSICIAN for Primary Care Center — Central Florida East Coast. Hospital affiliated with excellent potential for income and professional growth. Send CV to J.A. Sasser, M.D., 951 N. Washington Ave., Titusville, FL 32796. (305) 268-6556.

BC/BE FAMILY PRACTICE or Internists needed in Lee County, FL. Career opportunity; office & hospital practice in new office. Attractive financial package with option to buy in full or part. Send resume to: MED-CENTER PLAZA GROUP, INC., Attn: Martin E. Dolence, Jr., CPA, 6314 Corporate Ct., #C, Ft. Myers, FL 33907 or call for an appt. (813) 489-2227.

ST. AUGUSTINE, FL — OB/GYN male/female, American trained, to join Board Certified OB/GYN and Certified Nurse Midwife in free standing, fully equipped Woman's Center. Beautiful rapidly growing community on Atlantic Ocean. Ideal climate, located 35 miles from Jacksonville. Now's the time to move to Florida. Send resume or call: Anthony J. Mussallem, M.D., P.A. 2 St. Augustine South Dr., St. Augustine, FL 32086. (904) 797-3785.

OBERLIN, OH 20 person multispecialty group seeks additional BC/BE family physicians, internist, cardiologist, OB/Gyn and otolaryngologist. North central Ohio college town serving drawing area of 290,000. Salaried position first year; full shareholder status available in second year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074.

DAYTONA BEACH, FL — Freestanding walk-in medical treatment center. We are seeking a caring family physician, general practitioner or emergency medicine physician. Full-time physician wanted for busy walk-in Medical Treatment Center in a rapidly growing area. Less than 40 hr work week, excellent salary, fringe benefits, practice coverage and modern facilities. For more information contact: Carolyn Hood, Office Mgr., 1130 Beville Rd., Daytona Beach, FL 32014. (904) 253-6051.

THE DEPARTMENT OF Pathology is seeking an Assistant in Pathology. Candidate must have a Ph.D. in a biological science with a minimum of 6 years' post-doctoral experience in basic science research. This individual will be responsible for the basic science teaching and training of graduate students within the Experimental Pathology Program and teaching within the medical student pathology courses. This individ- will be expected to carry out an independent, extemally funded, research program in the area of molecular genetics of hematopoietic malignancies. As this will be the primary activity of this individual, demonstrated success in this area is required. Clinical service responsibility, to be shared with the present faculty of the Division of Hematopathology, will be the professional service, management and development of a clinical molecular biology laboratory for Shands Teaching Hospital at the University of Florida and related patient care areas. deadline for recruiting is 8/30/87 with a starting date of 9/1/87. Applicants should send CV to Raul C. Braylan, M.D., Professor, Dept. of Pathology, Box J-275, JHMHC, University of FL., Gainesville, FL 32610. Equal Opportunity/Affirmative Action Employer.

FLORIDA RURAL COMMUNITY — Close to big city looking for 2 family practice physicians. An emphasis in surgery would be ideal for 1 physician. Located in NW FL, one hour from the beaches, in a progressive community with good schools—a great place to raise a family. Contact Administrator D.J. Hammond, (904) 263-4431 or send your CV to 1305 College Dr., Graceville, FL 32440.

THE VETERANS ADMINISTRATION, Medical Center, Lake City, FL is recruiting for a board certified Psychiatrist. Will assist in estblishment of new Service in a progressive environment of inpatient and outpatient activity. Competitive salary plus incentive pay commensurate with qualifications. Liberal benefits plus malpractice insurance and retirement program. The North FL area offers an excellent climate year round, extensive outdoor recreational activities, lower than average cost of living, fine schools and nearby university, local community college, uncongested commuting to Medical Center. Contact John H. Beggs, M.D., Chief of Staff, VA Medical Center, Lake City, FL 32055, (904) 755-3016, Ext. 2011. An Equal Opportunity Employer.

RADIOLOGIST: Locum Tenens wanted. Board qualified for North Florida weekend coverage and part-time work. Must have experience in all phases of Diagnostic Radiology including CT and angiography. Send CV with inquiry to Box C-1400, P.O. Box 2411, Jacksonville, FL 32203.

DIAGNOSTIC RADIOLOGIST —Board certified with FL license. Experience with M.R.I. and interventional procedures necessary. Will consider neuroradiologist with similar experience. Hospital practice and two private offices. Send C.V. to c/o P.O. Box 599, Roseland, FL 32957-0599.

THE DEPARTMENT OF Pathology of the University of FL, College of Medicine is searching for a faculty member to do full-time research in the field of biomineralization. The candidate must have a Ph.D. in biological sciences and show evidence of recent research productivity. Applicant will be expected to do research devoted to mechanisms of mineralization during urinary stone formation and must have demonstrated prior work and expertise in this field. The candidate must be well versed in scanning and transmission electron microscopy, x-ray microanalysis, and electron microscopic cytochemtry. In addition, knowledge of basic lipidology techniques, and of methods of extration of lipids and non-lipid materials from human renal stones is essential. The candidate is expected to par-

ticipate in teaching graduate students, and in departmental and interdepartmental conferences and seminars. Close interaction at a professional level with members of the Division of Urology will be required. The deadline for receiving C.V. is 8/30/87, with an approximate starting date of 9/5/87. This is a tenure accruing position at the level of assistant professor. Salary is negotiable. Write to: Raymond L. Hackett, M.D., Assoc. Chairman, Dept. of Pathology, Box J-275, JHMHC, University of Florida, Gainesville, FL 32610. Equal Employment Opportunity/Affirmative Action Employer.

UNIQUE OPPORTUNITY FOR PHYSICIANS: Private practice of your specialty (exclusives given) Ocean Medical Center, Since 1969, serving affluent population of 40,000 in Galt Ocean Mile/Adjoining Beach Area. Urgently needed: Cardiologist, Plastic S., Pul. and Rheum. No salary, but will help with office rent. Call Collect: (305) 776-5800. 4001 Ocean Dr., Lauderdale-by-the-Sea, FL. Florida licensure mandatory.

SITUATIONS WANTED

LICENSED FLORIDA M.D. skilled in General Practice Board Certified OB/GYN. 25 years experience in private practice in Miami. 20 years chief of gynecology. Sick of threat of malpractice. Desires work in Miami with a hospital; HMO, insurance company, private group, cruise line, or will head a medical department or assist. Reply to: Box C-1403, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE PHYSICIAN: Board certified, Florida licensed, with extensive clinical experience in primary care, seeking employment opportunity. Available now, part or full time. Call: (305) 721-1978. Job must be within driving distance of Ft. Lauderdale. Or Write to: Henry Friedensohn, M.D., 3404 Willowwood Rd. Lauderhill, FL 33319.

HEMATOPATHOLOGIST, Board certified in clinical-anatomic pathology, has both clinical and research experience and Florida MD license. Seeks laboratory, hospital or group practice position. Write: Box C-1392, P.O. Box 2411, Jacksonville, FL 32203.

WANTED: INTERNAL MEDICINE or family practice in Palm Beach County or North Broward Counnty. Other exceptional practices also considered elsewhere in Florida. Call: (305) 622-7661, (305) 831-9305, Work: (313) 745-5111, Beeper: 8272.

EXPERIENCED NEUROLOGIST, BC, with 4 yrs' experience performing and interpreting MRI & CT of head and spine as well as carotid ultrasound. Seeks affiliation with group needing expertise in these areas. Reply to Box C-1403, P.O. Box 2411, Jacksonville, FL 32203.

PRIMARY CARE PHYSICIAN: with many years experience emergency medicine and family practice, currently working in a a walk-in clinic in Hillsborough County; would like to get 2 more days per week. Have my own malpractice insurance. Call: (813) 684-4773 or write Box C-1407, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST, Board Certified with FL license. Native New Yorker. Presently practicing in W.Va. Wishes to relocate to central or South coastal Florida. Interested in multispecialty group or group practice. P.O. Box 73, Dunbar, W. Va. 25064. (304) 766-7505.

FAMILY PRACTICE — Board Certified FL license, looking for private practice opportunity (solo, partnership, group) in Orlando. Willing to buy. Write: Box C-1415, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST WITH SUB-SPECIALTY training and FL license wishes to relocate along east coast. Write to Box C-1398, P.O. Box 2411, Jacksonville, FL 32203.

PRACTICES AVAILABLE

INTERNAL MEDICINE PRACTICE FOR SALE: in N.E. FL., well-established, excellent gross, will introduce. Write: Box C-1401, P.O. Box 2411, Jacksonville, FL 32203.

NORTH CENTRAL FL., General surgical practice, very active, conveniently located to hospitals. Due to contemplated retirement, would like to sell to two qualified general surgeons. Reply to Box C-1405, P.O. Box 2411, Jacksonville, FL 32203.

COASTAL PALM BEACH COUNTY established ophthalmology (anterior segment surgical) practice for sale. Office Surgical Suite, high gross, cost recoverable one year. Reply with CV to Box C-1397, P.O. Box 2411, Jacksonville, FL 32203.

RETIRING BOARD CERTIFIED OB/GYN selling or leasing completely equipped office. Capacity for 2 or more OB/GYNs. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone: (305) 667-3677.

INTERNAL MEDICINE PRACTICE FOR SALE: N.E. FL, well established, excellent gross. Will introduce. Write: Box C-1396, P.O. Box 2411, Jacksonville, FL 32203.

ACTIVE, WELL-ESTABLISHED, General Practice with bldg for sale. Gross $180,000 to $200,000 a year. Can be improved. Ideal for minority physician. FL Gold Coast. Write to: Box C-1413, P.O. Box 2411, Jacksonville, FL 32203.

ORTHOPEDIC PRACTICE FOR SALE. Excellent opportunity in general orthopedics, trauma, joint replacements, arthoscopy and back surgery for qualified physician. Lake City, FL. Write Box C-1414, P.O. Box 2411, Jacksonville, FL 32203.

BUYING A PRACTICE? WE have opportunities in all specialties. Quality and personal attention are our trademark. Call for information now. Frank B. Lane, M.D., Medical Dir., Medical Consultants of America, (813) 968-3878. Also private practice opportunities available.

FAMILY PRACTICE FOR SALE: High volume family practice, west coast of Florida, South of Tampa/St. Pete. Suitable for two physicians. Eight exam rooms all fully equipped, lab, x-ray, computerized business office. Expanding area, two local hospitals. For further information, contact Box C-1361, P.O. Box 2411, Jacksonville, FL 32203.

MIAMI BEACH AREA. Long established solo practice. Excellent terms. Will introduce. (305) 868-4835. Nights or weekends.

FAMILY PRACTITIONER — INTERNIST Board Certified, Private Practice. Opportunity to buy into large established practice. Excellent growth potential. Broward County. Unusual opportunity. Send CV to Box C-1401, P.O. Box 2411, Jacksonville, FL 32203.

REAL ESTATE

OFFICE SPACE TO SHARE with one or two physicians. 3,500 sq. ft. Full laboratory. X-ray machine. Excellent North Palm Beach location. Terms negotiable. Call John A. Swenson, M.D., (305) 844-2553.

MEDICAL OFFICE FOR SUB-LEASE in North Palm Beach on US Highway 1. Fully equipped with laboratory, x-ray, ECG, treadmill. Low rent. Call: (305) 863-5588.

OFFICE SPACE AVAILABLE to share immediately. 1,000 sq ft, 4 exam rooms, lab located in Piedmont Plaza, SR 436, Apopka, FL. Call (305) 886-2050.

ST. PETERSBURG BEACH— High traffice Corey Ave. Distinctive Cape Code style masonry bldg., ample parking, 2,000 sq ft of carpeted office space downstairs, 1,000 sq. ft. rental apt. upstairs. Minimum remodleing required for perfect professional offices. $164,000. We specialize in waterfront properties, homes and condos. Send for info. Lona Lubin, Realtor-Associate. Alan Bliss Realty, 8351 Blind Pass Rd., St. Pete Beach, FL 33706. (813) 345-8246.

SERVICES

UNSECURED LOANS: No collateral, confidential, $5,000 to $60,000, competitive rates, no points, no repayment penalties. Information, application, Call (800) 331-4952, Department 32 or write: P.O. Box 9739-J, Pompano, FL 33075.

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

DISTRIBUTORS, BUYERS, of high technology diagnostic medical intruments. Holters, Scanners, ultrasound, EKGs, ICU monitors, defibrillators. New or reconditioned. Contact: Ed Tell, New Life Systems, Inc., P.O. Box 8767, Coral Springs, FL 33075, (305) 972-4600 or (800) 330-TELL.

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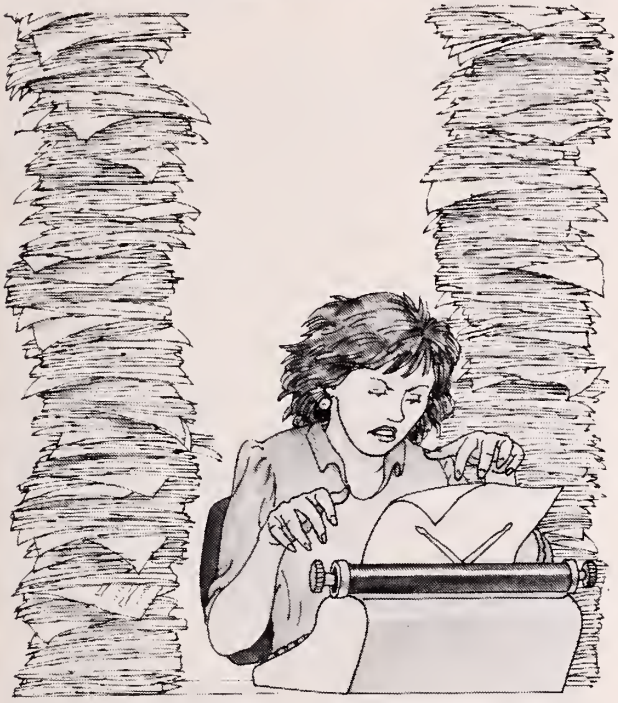
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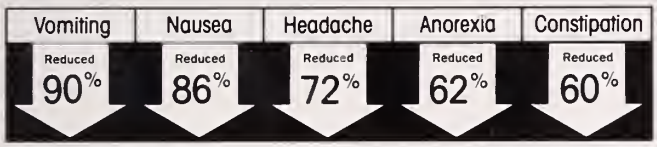
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See the difference in the first week[1]

- **Sleep improvement in 74% of patients after first h.s. dose[2]**
- **Significantly faster relief–62% of total four-week improvement evident in first week versus 44% with amitriptyline alone[1]**
- **Dramatic first-week reduction in somatic complaints[2]**

% Reduction in Somatic Symptoms[2]



- **Only ⅓ the dropout rate due to side effects of amitriptyline alone, although the incidence of side effects is similar[1]**

Caution patients about the combined effects of Limbitral with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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Protect your decision.
Write "Do not substitute."

In moderate depression and anxiety

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

References: 1. Feighner JP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ

Limbitrol® (IV)
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets*, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets*, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 50.

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The rewards of Limbitrol
You're both smiling again!



See the difference in the first week[1]

In depressed and anxious patients, you can see the difference sooner—62% of total four-week improvement achieved in the first week with Limbitrol versus 44% with amitriptyline.[1]

In moderate depression and anxiety

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and [illegible]ine (as the hydrochloride [illegible] (IV)

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Please see summary of product information on adjacent page.

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...we had
to find
just the
right room.

60,073 patients (90%) who started on INDERAL® LA stayed on INDERAL LA.[1*]

Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.
A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol — which shows how well-tolerated once-daily INDERAL LA can be.

Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were treated merely with the addition of a diuretic to INDERAL LA.

For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

Control, comfort, and compliance

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

NOW AVAILABLE...
NEW LOW DOSE
INDERAL LA 60 mg
(PROPRANOLOL HCl) LONG ACTING CAPSULES

Please see next page for brief summary of prescribing information

The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period, the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

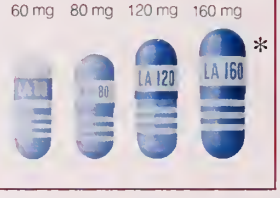
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, vivid dreams, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy and vivid dreams appear dose related.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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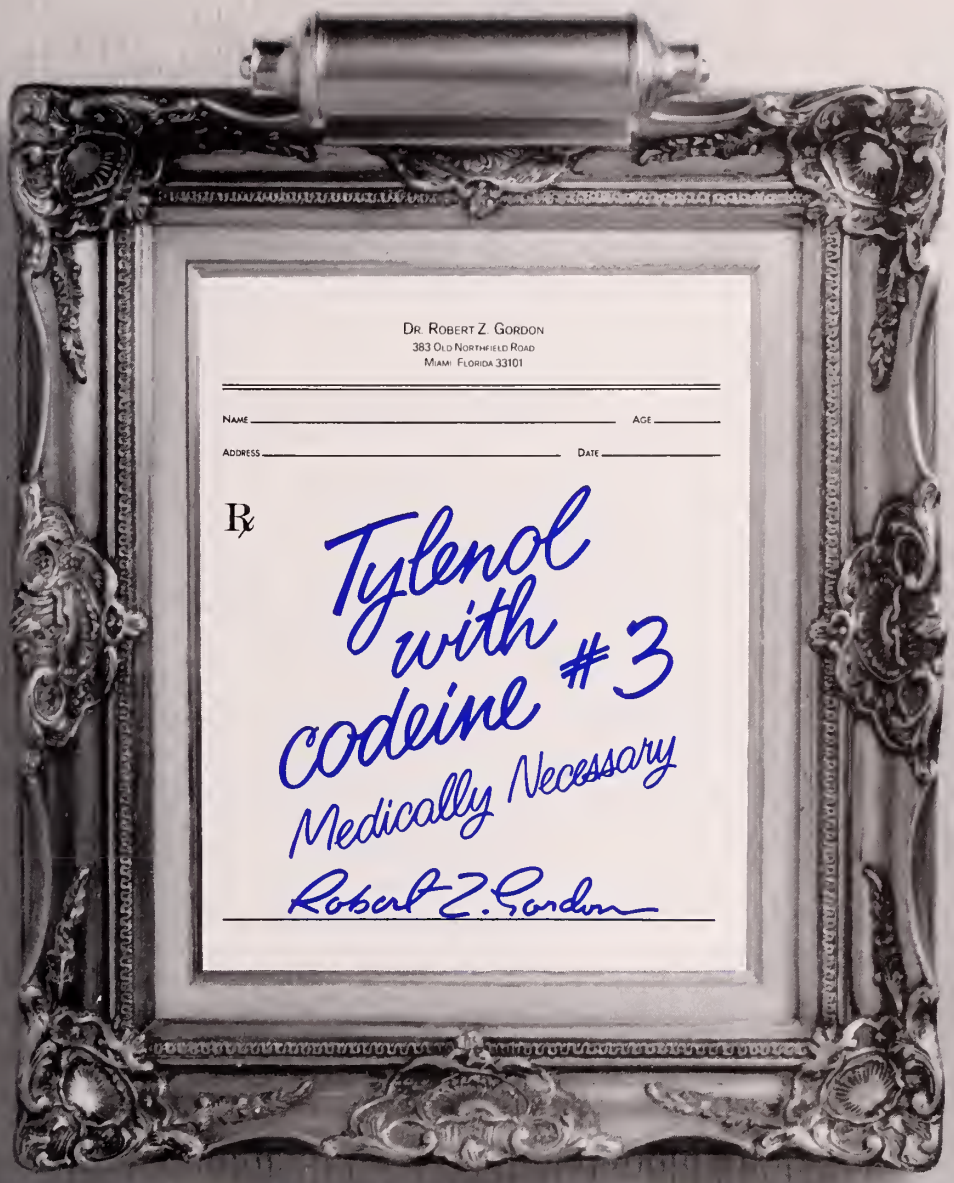
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AUGUST 1987, Vol. 74, No. 8

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This month's cover of *The Journal* is an illustration by Jacksonville artist Chris Armstrong depicting the theme of this Special Issue, Medical Ethics.

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AIR FORCE



Dedicated to ethics



Every thing and every place must have its own relationship as an integral part of the whole.

As I approach the end of an eventful year, the theme of which is partially clarified in this issue of *The Journal*, realization of a doctor's place in his environment is of paramount importance. Ethics, care delivery, concern for patients, the environment, love of country and government; and perhaps most of all, ourselves, are assimilated into our ethical and moral reactions. Our thoughts, conscious and subconscious, are the driving force of our ethical actions, motivated directly and indirectly by cognizance of many, if not all, these factors. This helps to make us function.

At the Smithsonian Institution a few years ago, I recall reading the story of a man lying on a beach in Chicago. It mathematically viewed him at one power and then up to ten to the twentieth power and then back to ten to the minus twentieth power. I may well have the exponent numbers wrong! The striking message, however, was that at the far end we are out in the infinity of space well beyond our galaxy and its nebula where even it cannot be seen. At the near end we see the lattice work of the carbon atom that is a piece of dust on the back of man's hand. From the most minuscule portion of even a fraction of the size of a virus to the expanse of the universe, here, we, as men, exist on a beautiful planet. It is "unique" in that arena, and as but one person; we as occupants of that body, exist in today's "world."

To put this into time sequence rather than place and person, reflect for a moment on a newly seen super nova. It was observed in February 1987, and that in itself is interesting. This giant body, much larger than our own galaxy of which our sun is but a minor star in the outer spiral, is 160,000 light years near. What we saw with that galaxy happened before our Earth was formed. Yet we see it just now in its own formative stages and even this month a companion less that ten lights years from it is being seen! Thoughts which can be construed when thinking about such phenomena are more than mind boggling. Let's discuss them! Better yet, instead, let's think about the here and now.

Our individual and intense need is to look at number one—ourselves. It is important to consider our relationships, your relationships, your necessary support structures, your desires for self-preservation and survival. In earlier notes we have reflected upon the premise that no man is an island and he is interdependent. Perhaps, through oversight and maybe not, cognizance of ourselves has been overlooked. Where are we in the fight for self-preservation, self-betterment, self-love. These are part of the fuel of daily living. Yes, dependent, more so than we care to think, on our families, our spouses and our heirs. They above all need us healthy in mind and body just as we need them. If, as is frequently the case in our imperfect society, something goes astray in this family chain, every emotion imaginable comes into play. In reflecting upon emotions it is interesting to look and digest most of them and realize that perhaps above all others the most important must be fear. I suspect that fear is the energy from which most if not all others come.

Yes! Perhaps love is there before fear. I suspect also that in biblical times this led to the most important

commandment exposed by all religions: *Love the Lord, thy God...''*

And the Second Commandment: *Love thy neighbor as thyself.*

Today, I should like to choose the ''thyself.''

Perhaps this is what ethics is all about. Perhaps that is what the essence of life is all about. To bring this all back to this issue of the *Journal* and to our place in the here and now is important. We can begin with this and progress to any issue facing us as physicians in the malestrom of problems that each and every inhabitant of the earth faces every minute of every day. In this society the love of self and the fear that causes us to react in a protectionistic manner lead to our desire for food and shelter first. To some this can be excessive, but justified; otherwise our motivation is suspect. This may represent a bench or a steam grate to the poor our country. From there up the economic ladder begins an accumulation that eventually can be clarified as the epitome of success. The White House, our Governor's mansion, or perhaps a castle or a home on the water in Ft. Lauderdale. Perhaps even three or four homes. An excess? Who knows or can say or can criticize without first examining, once established at a level of survival, their own place in the universe. From this accumulation we must then expand and yet another emotion occurs, and that is fear. We must protect our food and shelter.

Is this what leads to political decisions all over the world and then from a country standpoint to acrimony and war? Is that what causes loss of life, and loss of emotional equanimity. Probably but more than that, does the frustration then lead us to illnesses like obesity, atherosclerosis, coronary artery disease, hypertension, diabetes, mental illness, even cancer and ultimately death?

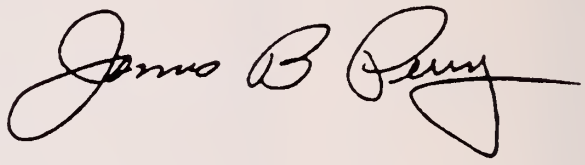
If this is possible, then why? Because we lose sight of our being; or is it all simply and totally existentialism at its ultimate. We as intelligent, thinking creatures of God can fortunately discuss this forever and, perhaps, that is good and as it should be.

This year has been a battle born of fear, honed in the papers, the legislature, and endless meetings, and literally thousands of conversations. Out of it—who knows?

Perhaps, the battle over liability, over AIDS, over big government, will be won soon for the betterment of all. However, since we are all human and we are on this small dot in the universe, there will be other battles, other wars, other crises, and, yes, there is no finish line. But there is an answer to all of our problems. As our Lord said: *LOVE*. This special issue of *The Journal of the Florida Medical Association, Inc.*, dedicated to ethics is about that.

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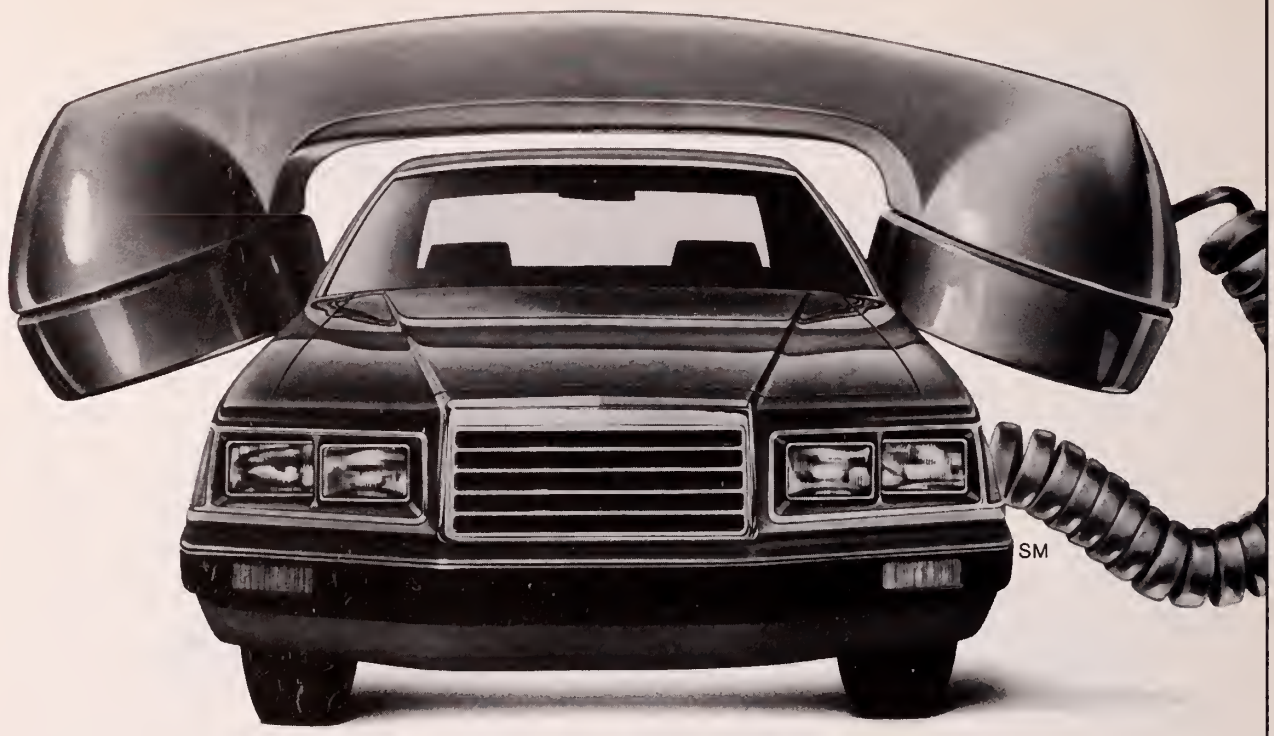


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EDITORIAL

The task force report on tort reform: A bugle call for drastic changes

The preliminary report of the academic task force created in 1986 to study the insurance and tort systems confirmed what physicians knew all along: that the current malpractice crisis came about principally because of increasing litigiousness by patients and the rising number of excessive malpractice awards. These findings, along with the outrageous legal fees that were being doled out, reflect the brutal aberrations of a tort system that is threatening to destroy medical care in Florida and elsewhere.

On the heels of this report, submitted to Gov. Bob Martinez in anticipation of a special session he plans to call soon to deal with the malpractice problem, HHS Secretary Otis Bowen issued the findings of a government study echoing essentially the same conclusions reached by the Florida academic task force. He warned of an impending national crisis in health care unless states took drastic steps to stem the spiraling liability premiums and the soaring malpractice awards.

The FMA, in retrospect, was right all along in doing what it had to do in dealing with the problem during the past ten years. It was right in getting the legislature to create mediation panels in the mid-70s and to pass a cap on noneconomic damages in 1986, only to be rebuffed each time by a hostile trial bar and an unsympathetic state Supreme Court. These setbacks, along with exorbitant premiums, only deepened what was to become a full-blown crisis in south Florida.

The major findings of the academic task force should also lay to rest the canard that physician incompetence is behind the malpractice crisis. To be sure, there are a few "bad doctors" (as there are a few bad apples in every profession), but it is foolhardy to believe that these few doctors are causing most of the problems when a number of those being sued are some of the most highly trained in the profession. No matter how sophisticated medicine has become, it is not a perfect science and the public and trial lawyers must not be led to believe that every untoward or adverse outcome was the product of an error or negligence by the physician. The fact that some doctors have had two or more malpractice claims filed against them also brought a strong caution from the task force report that they are not necessarily incompetent. It may mean that their practices entail more risky procedures, as is true for a number of surgical specialists.

What about the much bandied profiteering by insurance companies that trial lawyers and a few newspapers have been braying about? Although the task force found medical malpractice insurance to be slightly more profitable than property-liability insurance, it dismissed profiteering as a reason for the affordability problems being experienced by a number of physicians. The report also added that the profitability for insurance companies varies dramatically from year to year.

Of the millions of dollars being paid out yearly by the insurance companies, lawyers are getting nearly as much (40%) as the patients (43.1%). Contingency fees, as everyone knows, have made the tort system a gold mine for lawyers. In addition, since 1976, the cost of defending a malpractice claim has increased at an annual compound rate of 17%. Since trial lawyers have been so vociferous about having insurance companies investigated for their alleged excessive profits, maybe it is time to turn the tables on them and ask that a study be done on why their fees are so outrageously exorbitant. The task force, it is hoped, may elaborate on this in its final report in March 1988.

Even while the findings of the academic task force are preliminary, an unbiased analysis of the report leads to one inescapable conclusion: there are fundamental flaws in our tort system. Trial lawyers love to spout the line that the tort system is necessary to protect the rights of individuals to seek redress for their injuries. Nobody quarrels with individual rights but the abuses permeating the system have outlived what it was created for and have made a mockery of fair play and justice. A lot of greed is now driving the system, fueled both by litigious individuals and trial lawyers who stand to gain the most from it. I think lawyers ought to understand that there is a crisis of confidence in the tort system when almost every segment of American society is demanding relief from its choke-hold on them.

For physicians in particular, the urgency of finding a solution to the liability problem cannot be overstated. The state legislature must focus on its efforts towards addressing the major problems contained in the task force report. That means finding ways to decrease litigation, perhaps through mediation, a medical-incident compensation system, or screening panels to weed out frivolous and non-meritorious suits. That means putting a reasonable cap on noneconomic damages, as Gov. Martinez is suggesting. That means limiting contingency fees for lawyers. Or, as many people have suggested, that means considering taking medical malpractice entirely out of the tort system.

For its part, the medical profession needs to reassure the public that it is interested in purging its ranks of incompetent doctors. The common public perception that physicians are coddling their bad colleagues simply is not true. The problem is that physicians, under the current set-up, are limited in their ability to discipline the incompetents, or to take their licenses away. The Legislature ought to consider passing legislation to facilitate weeding out the bad doctors, and to give immunity to those charged with overseeing the performance of physicians. The Department of Professional Regulation also needs additional infusions of money and personnel to do the job that the public wants.

As for the insurance companies, there is an obvious need for tighter regulations to assure, among other things, that they show more responsibility to those that they insure. The spectre of insurance companies doing business when business is good and then leaving their clients bare and empty when business is not so good should not be visited upon physicians again; those that do so ought to be fined and perhaps barred from doing business altogether.

With the major findings of the academic task force out, there is no further reason for the Legislature to pussyfoot about finding a permanent solution to the malpractice crisis. There is too much at stake here — the continued availability and affordability of good medical care to citizens of Florida — for the Legislature to continue to ignore the problem. Other states, including California and Indiana, have succeeded in passing meaningful tort reforms and in the process have averted a crisis that Florida is now experiencing. We ought to establish the same sanity here.

R. G. Lacsamana, M.D.
Editor

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Compassion: Dead or alive?

One of the reasons why I left my job as a civil engineer to pursue a career as a physician was my self-perception as a compassionate individual, good listener and people-person—all attributes, I thought, which were necessary to become a good doctor (but not necessarily a good engineer).

I heard the dean of students speak at a preprofessional honor society meeting shortly after I enrolled as a postbaccalaureate student. The head was listing the three factors, in order of importance, that determined whether one was admitted to medical school. I listened carefully. "Number One—GPA and MCATS*," he said as he extended his pinky in the air. "Two," he continued with authority, shooting out his ring finger, "Recommendations." "Three," he went on as he flicked his middle finger up to join the other two, "The Interview."

What about personal attributes, personality, compassion and other nonquantifiable charateristics? They were important in my mind; I wondered if the admissions committee felt the same. In my personal essay, when I applied to medical schools, I used the words, "empathy, sincerity, and compassion" to describe virtues I thought important in a good doctor. I contemplated the meaning of those words and how they applied to the medical scene.

Looking back over my first two years in medical school, I unfortunately rarely heard those words. I can only recall one professor who emphasized those qualities as an underlying and recurring theme in his lectures. Virtually all the others maintained the basic sciences as dry as the engineering courses I took years ago. But so what, some might ask. You can't teach compassion and, besides, being compassionate is part of the altruism that accompanies the desire to become a doctor. I'm not so sure; however, on either account.

Meaning of compassion • Since Webster's is to the English language what Harrison's is to internal medicine, I must refer to the former for a proper definition. Compassion is "Sympathetic consciousness of others' distress together with a desire to alleviate it."[1] The "desire to alleviate it" follows the charge of medicine (to relieve suffering, prevent premature death, restore functioning, and provide information about an individual's condition[2]) and is inherent in the nature of the profession. However, without "sympathetic consciousness," one is merely a health technician dispensing health care much as a pharmacist dispenses drugs.

Compassion in the real world • The American Medical Association adopted seven principles of ethics in 1980. The first one states: "A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity."[3] Though not law, the principle defines standards of conduct which are the essentials of honorable behavior for the physician. Compassion then, at the very least, is recognized in print and in principle. But what role does it play in real life? Allow me to share a vignette...

> I know a highly regarded internist who once thought of himself as an ace physician who could tackle and solve any medical challenge. He told of one patient who gave him particular problems and, in the process, left him a bit more humble. The patient was overweight and unattractive by medical and societal standards and did not respond to the medication he prescribed

* Grade Point Average and Medical College Admissions Test

("as she should have"). The woman returned week after week with no improvement in her condition. My doctor-friend changed the medication, tried every appropriate therapy covering every gambit—all to no avail. She was no healthier than in her initial visit. Several frustrating months and numerous visits later, in a moment of fury, he pounded his fist on his desk, looked at her and practically yelled, "What's wrong with you?!" After a brief pause, the woman answered timidly, "Doctor, I'm lonely."

The hot-shot internist was taken aback. Loneliness, after all, was not a disease. When he regained his composure, he began talking to her, inquiring about her life and listening to her fears and worries. He made suggestions and gave her ideas on how to improve her nonexistent social life. They interacted. And yes, in the ensuing weeks her condition improved (as it should have).

Norman Cousins, author and lecturer on medical humanities at the UCLA School of Medicine, recently examined how patients appraised their physicians. He wondered if compassion and communication were able to at least gain increased respect in medical practice even if those skills were not readily quantifiable. In a *New England Journal of Medicine* article, he commented that many medical students "...tended to regard the entire area of patient-physician relationships as soft. They seemed reluctant to attach appropriate importance to the physician's communications skills, to medical ethics, or to the circumstances of a patient's life."[4]

Cousins distributed 1,000 questionnaires in his University neighborhood (a nonscientific survey, he readily admits) asking three questions:

1. Had the respondent switched physicians in the past five years or were they thinking of changing now?

2. Why had they or why were they thinking of changing? and

3. Did they have any suggestions to make about the education of medical students?

Of the 563 responses, two surprising findings were noted:

85% of the respondents had either changed physicians in the past five years or were thinking of changing for reasons other than relocation, physician retirement or death, etc.

Only 25% of those switching cited incompetence on the part of the physician as the reason for doing so.

A majority of the reasons for switching had to do with the style or personality of the physician, poor communication skills, inability to arouse the patient's hopes and inability to inspire confidence in the patient.

Some comments of the respondents were quite to the point and merit direct quotation:

"My doctor was not as sympathetic as I needed him to be."

"I had the impression my doctor was not really listening to me. He could hardly wait to get me into medical technology."

"I really didn't understand what the doctor was saying and was too embarrassed to ask."

Conversely, the overwhelming majority, according to Cousins, once having made the change, expressed satisfaction with their new choices—giving positive reasons in the same respects as the earlier responses were negative.[4] Respondents suggested more emphasis be placed on communication and listening skills in educating doctors to be.

Enemies of compassion • The intense pace and academic pressures of medical school are well known to those inside and outside the lecture halls. As a medical student, I have heard the grueling statistics...10% of physicians are estimated to have a significant psychologic impairment; 7 to 10% are dependent on alcohol or other psychoactive drugs; and because of easy access, narcotics addiction in physicians is 30 to 100 times more common than in the general population.[5] Other studies show equally unpleasant figures about suicide and unhappy marital relationships.[6] How can compassion survive with all the pressures? One Harvard resident found his environment to be extremely unfavorable; in a poignant essay, he bitterly complains about his treatment during his postgraduate training:

"They have a way of making you feel worthless. Where they're coming from or why they feel so superior, I don't know, but I think it's ironic. We work like slaves, get very little sleep, and have no formal didactic teaching to base our knowledge on the vast field of surgery..my self-worth and sense of competency have had to come from within. They've done everything they can to tear it down. This experience did not build character, strength or 'make a man' out of me..It is sad that people so bright and so famous have lost the ability to do simple thing...to treat all people as equals."[7]

To me, the above essay is a sad reflection on the system and is a cry for reform. After all, "sympathetic

consciousness of others' distress'' should start in one's own back yard.

Helping compassion live • While ''compassion'' defies most attempts to be measurable, I believe some measures can and should be taken to enhance its role in medical education. First, more student interaction with appropriate role models needs to be incorporated into the curriculum along with an avenue to nurture communication skills. Second, the stressful environment that may intensify animosity and/or emotional problems which can be detrimental to quality patient-physician interaction must be recognized and dealt with. Third, the importance of personal characteristics must play a stronger role as a corequisite to the medical school admissions process. Some institutions presently practice some of these measures. A few examples: A UK medical school has modeled an introductory course in teaching communication skills to medical students in a preclinical context with an enthusiastic response by students. Novel features includes active participation of selected patients in teaching and assessment and the use of a form of role-play named ''listening triads''.[8] The University of Miami School of Medicine established an office of student mental health and hired a full-time psychiatrist in 1975 to address the emotional problems that confronted students. Besides helping the student alter maladaptive patterns for dealing with stress, an additional side effect, according to the dean, ''is that the physician will be more attuned to the emotional needs of their patients...''[9] And finally, at Newcastle Medical School in New South Wales, Australia, dissatisfaction with traditional selection methods led to creation of a multistage approach that uses tests of problem-solving ability, empathy, creativity and moral dilemmas to screen applicants otherwise suitable on academic achievement.[10] One reason for developing such a program was the recognition that patients wanted their doctors to be caring and understanding.

I believe that medical schools in this country should adapt alternative and creative ways to select students and reflect some of the same ideals already mentioned. Then perhaps one day, at a preprofessional honor society meeting, the dean of students could extend his index finger out to join the other three and add ''compassion'' to the list.

Final thoughts • Not long ago my small town's newspaper ran a front page headline, ''A surgeon in town who really cares.'' In the article, a patient comments about his doctor: ''I don't know a finer man. He's an intense, caring person, a loving person. Some doctors are glorified technicians. To them, a patient is a problem that's in front of them. But to Mike, it's a person.''[11]

No, compassion is not dead, to answer my first question. But it is our mandate—as students, educators and physicians—to keep it alive.

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Howard E. Richmond
Medical Student
Gainesville

Minimizing motorboat propeller injuries

I enjoyed very much the motorboat propeller injury article by Dr. Price and Dr. Moorefield in the June 1987 issue of the *Journal*. I think they've done a great service in bringing to print the high incidence of boat propeller injuries, and I think it is probably even greater since 1983. I live in the Miami area and have seen a few myself as well as read about them in the paper on a fairly regular basis. I have to agree with them for the need of better regulations, enforcement, and knowledge of the operators and maybe a solution would be licensing in the State of Florida, which seems to be slowly working its way to reality.

I, however, totally disagree with the development of propeller guards as a preventive measure. A propeller guard going through the water at 25 to 30 mph will cut up somewhat just as badly as a propeller will, and, in fact, may slice hugh chunks and may disfigure someone more greatly because of its bluntness.

The other issue is the performance of boats and the technology that has gone into performance of propellers, motors, and boat hulls. This has enabled a wide range of pleasure boats to be developed which are fuel efficient and easy to run. Propeller guards would most likely set this back decades. I need not mention that water is 700 times denser than air so the drag factor on these would be almost prohibitive and we might cancel out the use of any propeller driven boats should this measure be enacted.

I think the most fruitful area is, as mentioned, enforcing the present regulations, better regulations, licensing with improved education of the operator of the boat, because therein is the source of the problem. Once cannot put a steel lid on the front barrel of a pistol and find it useful.

John C. Nordt III, M.D.
Coral Gables

It would be worthwhile to extend the investigation by Drs. Price and Moorefield to elicit further data concerning these accidents—i.e. age of boat "captain", evidence of alcohol or drug use, etc. Although the propeller is doing the damage, someone is "driving" the boat.

As a matter of interest, Yamaha Motors has designed and is selling a propellerless motor for use in shallow waters. (Again scooped by Japanese ingenuity.)

Perhaps a Coast Guard Auxiliary Boating Course should be mandatory for anyone in charge of a boat.

Paul B. Welty Jr., M.D.
St. Petersburg

Dr. Bolivar's chair in surgery

It has been brought to my attention that an announcement made in your Notes and News quoted the amount of money needed for the establishment of a Chair in honor of the late Dr. Juan C. Bolivar. In the last paragraph of this announcement you said, "An estimated $1 million will be needed for the establishment of the chair." This is an eminent scholars chair where we needed to raise only $600,000 and have raised all but $100,000 of this amount. The State matches contributions of $600,000 with a $400,000 contribution to create a $1 million Chair. The reason I call this to your attention is when the amount $1 million needs to be raised, it may seem overwhelming and I think in essence it discourages people from donating. Also, I would like them to have a very positive outlook and realize that we do not have a lot more money to raise to finalize the Chair.

Richard G. Connar, M.D.
University of South Florida
College of Medicine
Department of Surgery
Tampa

Political militancy by physicians needed

Physicians are normally very aggressive in treating medical disease and helping their patients stay well or get well. However, physicians have been extremely nonaggressive in their attitudes towards trying to influence legislation involving health care in general and tort reform in particular. Despite all of the previous set backs in attempting to achieve tort reform in the State of Florida, we continue to patiently wait for Governor Martinez to call a special legislative session to try and answer some of the problems that have made many physicians in the State of Florida despondent, retiring and refusing to treat patients, which is the livelihood and essence of a physician's life.

Most physicians throughout the state have empathized with the physicians in South Florida who have been so devastated by the costs of professional liability insurance, and have eagerly awaited some attempt at resolution of their problems. However complacent the remainder of the state may be, it is obvious that these problems are not unique to Dade and Broward Counties but are our problems and the economic hardships created in those counties will be ours within one to two years, even in the most rural of Florida counties.

I think it should be the responsibility of the State and the County Medical Associations to appropriately inform the public, using all the media available, that the problem caused by the lack of tort reform is the unaffordability of professional liability insurance, rather than its unavailability. The efforts by our Insurance Commissioner, Bill Gunter, at increasing the availability of insurance certainly will not relieve us of the problems associated with cost.

My main purpose, therefore, in writing this letter is to try and direct our efforts to utilize the power and strength that we have as a pressure group to ensure that tort reform legislation is passed before the end of 1987. We cannot afford to wait for 1988 for relief. We must emphasize to the governor and to our legislators that we will act in some way if they fail to act.

My suggestion is this: Unless they are able to come up with a tort reform package before December 31, 1987, I suggest that we as physicians throughout the State of Florida agree to drop all malpractice liability insurance as of January 1, 1988. Our reason for doing this is unaffordability. Since doing this will prevent us from practicing medicine according to law, this essentially will result in a physician walk-out throughout the State of Florida. However, it must be emphasized that the reason for the walk-out is not a "strike" but inability to afford malpractice insurance.

Our reasons for instituting tort reform have been stated many times in many editorials and in many let-

ters. The time for action is 1987. We must also indicate to the legislators and to the governor that if we do not act in concert in this direction, physicians will be leaving the state or retiring early, or in other ways restricting their medical activities. The effect on the citizens of the State of Florida will be catastrophic.

There is another bargaining point with the governor and the legislators that may well be even more significant; that is, the economic impact that adverse publicity will cause by directing our efforts at those people who have been moving to Florida in large numbers over the past few years. I believe we could interest the chambers of commerce in helping us in this direction by indicating to them the adverse effect toward further growth of Florida by the knowledge that medical services will be greatly curtailed in the future if we do not get the tort reform relief we are seeking.

Thirdly, we must also direct our efforts at continuing to interest the business community in helping us with total tort reform, not just medical liability reform, considering that the total liability problem in the State of Florida is out of hand.

Therefore, it is my opinion that political action should not slide by during the slow months of the summer and allow physicians in Florida to continue their constant state of anxiety concerning the future of their practices in this state. I think efforts towards constitutional amendments and affecting legislators by using words supplied by other attorneys is to no avail, and I would greatly oppose any further efforts in this direction without utilizing our strengths and, yes, using blackmail tactics as I have outlined above if necessary in order to achieve our goals. The time for being patient and easygoing has long past gone. We must be militant if we are to achieve our goals and resume the kind of medical practices that we have enjoyed in the past and by these means control the medical costs of the future.

Edwin R. Lamm, M.D.
Lakeland

The ultimate suit

Since the dawn of civilization man has gone through the process of being born, living, and dying. There were no guarantees man would survive life without undergoing suffering. But the attitude of no guarantees has undergone changes during the past few decades. Suits were started because suffering and misfortune must be someone's fault, therefore, sue for damages. At first, these sought-after guarantees were limited to the person's lifetime. Lately, these suits have extended beyond life. Suits have been brought seeking damages which occurred while the individual what in utero. Other suits have been brought after the death of an individual. As an example, a case has survived in our court system where a five-year old girl and her father sued the girl's mother for negligent driving for damages sustained while the girl was in utero. The girl suffered birth defects which were said to be related to her mother's driving negligence.

I think America is ready for the ultimate lawsuit. The ultimate lawsuit would be to sue God. People suffer damages by the acts of God, such as tornadoes, lightning, etc. These have bee passed off simply as acts of God. However, if the person is lucky enough to live in the United States and there are damages suffered then someone must pay. If the suffering results from the act of God, then the only logical course would be to sue God.

Suing God might sound preposterous; however, such a suit would be viable in our legal system. The logic would be thus: if God is responsible, then he should be sued. However, it is impossible to obtain monetary damages from God. Therefore, the legal process of joint and several liability would be pressed into service. God's representatives on earth, namely the churches, would also be included in the suit. Therefore, money would be available and damages would be reimbursed. The churches would be required to list their assets so that the maximum amount of damages could be sought. In the American legal system the amount of damages sought depends on the amount of money available. Since the combined wealth of the churches, who represent God, would be in the billions of dollars, the billion-dollar suit would be common.

To progress further with the ultimate suit, the United States government could also be named as co-defender. The legal thinking would proceed thusly. The United States coins have an inscription, "In God We Trust." This implies that God is trustworthy and can be depended upon. However, when a victim is damaged by an act of God, the trust has been breached. If this trust was recommended by the United States government, it should be responsible and be brought into the suit. Damages sought could be in the trillions.

Damaged citizens of the United States, let's sue God!

J. N. Brouillette, M.D.
Winter Park

IMC-HMO article: A correction

The author wants to correct an error in his article, "The IMC-HMO fiasco," which appeared on pages 473-474 of the July 1987 issue of *The Journal*. The AMA officer reported in the article as having been a contractual physician for IMC patients related to the author that he never provided any care to IMC patients nor received any remuneration from IMC. The surgical group to which this physician belongs did sign a contract with IMC but the AMA officer withdrew from participation early after the contract was signed.

Richard J. Feinstein, M.D.
Miami

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Overview

Ethical concerns in medicine

There is a conviction among all civilized and educated men and even among primitives who are neither civilized nor well educated, that there is a fixed difference between good and evil.

Edwin F. Healy, S.J.

Last August, President-Elect Jim Perry asked us to develop a special issue of the *Journal* on ethics. At the same time, Dr. Perry established a statewide Special Committee of the Board of Governors on Ethics. This committee is chaired by Charles J. Kahn, M.D., and is charged to identify, review and evaluate those important ethical issues that continue to develop in the practice of medicine. The special committee was instructed to organize and implement forums, symposiums and discussions to enhance physician awareness of the ethical issues that affect us all. In addition to the physician members, the committee consists of a priest, state senator and attorney. At the October Board of Governors meeting, Father Vincent Kelly commended the Board and the Association in his nine-page presentation for "emphasizing ethics in the profession." Since the October meeting, the FMA has held numerous programs on ethics throughout the state including an excellent and well-received half-day symposium at the March Leadership Conference.

Just 15 years ago, the ethics course in most medical schools concentrated on such areas as physician advertising and consultant fee splitting. Today, at least, what little time there is devoted to ethics is usually taught by a Department of Human Values in Medicine and students are given some basic principles to assist them in dealing with the very complex and philosophical aspects of medical ethics in the 1980s.

Even if one devoted full time to the study of what is considered medical ethics today, one would be both enthused and frustrated as it is apparent that new problems develop before old ones are solved.



Dr. Bouis



Dr. Smith

We have selected a set of articles designed to illustrate the breadth of ethical concerns in medicine while at the same time focusing on the special role of the medical profession. A number of our authors have been especially concerned with the influence of ethical considerations on how doctors carry out their role of healer.

In "Telling Stories as a Way of Doing Ethics," David Smith, Ph.D., examines the resistance by some doctors to the bioethics movement and finds the basis for their resistance in the emphasis on the question of principle in bioethics. He offers the questions of values and virtues as alternatives and describes how physicians can use narrative as a method to answer those questions.

Father Kelly in the "Challenge of the Ethical Life in Medicine" finds similarity between the challenges faced by the priesthood and those faced by the medical

profession. He details ethical pitfalls to be avoided and pressures that must be endured by contemporary doctors. He offers a Physician Examination of Conscience to help in the review of personal and professional goals.

We were delighted that the President of the Society for Health and Human Values agreed to let us reprint his article, "Medical Ethics and the Medical Entrepreneur: Are They Compatible?" Dr. Jonsen "digs into" the archeology of medical ethics and unearths four levels: self-interest, altruism, competence and justice. He finds each worthy and useful. He explains that the entrepreneurial spirit can be consistent with the traditions of medical ethics as long as all levels are served. It is only if self-interest takes over humane concerns at the other three levels that entrepreneurship can undermine the value base of medicine.

We often find fact in fiction. Dr. Howard Carter's story, "The Pale Blue Eyes of Jeffy Glick," takes us inside the thoughts and feelings of a young physician as he confronts his own limitations and those of medicine in dealing with the death of a young boy. Dr. Carter helps us examine the meaning physicians can find in their professional lives.

The meaning of medicine is also central to Dr. Yvonne Cummins', "Metaphors in Medicine: A Concept of Physicianhood." She uses morning rounds in a teaching hospital to launch a consideration of the military metaphor in medicine and current challenges to physician humaneness. She calls for changes in physician training to emphasize human values.

The problem of providing food and fluids to the terminally ill is among the most current challenges presented to medical ethics. Ray Moseley, Ph.D., and James Jernigan, M.D., analyze the impact of Florida law, a recent court case, and ethical arguments in "Withdrawing Medical Treatments: The Difficult Case of Withdrawing Nutrition." They argue for change in Florida statutes to make it easier for physicians to end treatment when treatment is futile, of no benefit, and disproportionately burdensome.

Our final articles tell of the work of two important statewide ethics committees. First, Wally Graves, M.D., describes the creation and work of the Florida Medical Examiners Commission Ethical Advisory Comittee. The first such committee in the nation, it has in the last year issued a landmark set of guidelines and become a standing committee of the Commission.

Second, Dr. Kahn discusses the outlook for his committee's work.

We thank our authors and all those who have assisted with this special issue. Special thanks are due to the *Western Journal of Medicine* for permission to reprint the Jonsen article. We hope our work will be a worthy symbol of the commitment of the Association to the importance of the ethical dimensions in physicians' professional lives.

It is with this background that we bring you this special issue of *The Journal*. As editors, it is our desire to provide insight into this very complex area of medicine by giving you, the reader, various considerations of medical ethics on a state and national level.

Guest Editors

PIERRE J. BOUIS JR., M.D.

Associate Dean for Continuing Medical Education, and Associate Professor of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa; Chairman, Council on Scientific Activities; Member, President's Special Committee on Ethics, and Contributing Editor, The Journal, Florida Medical Association.

DAVID H. SMITH, Ph.D.

Professor and Chief, Division of Human Values, Department of Comprehensive Medicine, University of South Florida College of Medicine, Tampa; Member, President's Special Committee on Ethics, Florida Medical Association.

Telling stories as a way of doing ethics

David H. Smith, Ph.D.

Beneficence • Medicine has long been a profession characterized by a special ethical commitment. The roles of healer and priest overlapped in the early mists of history and are not always easily separated even in our scientific and technological society. The very definition of health contains an important value assumption. "Healthy" can be easily equated with "good." But what is a good life? One that is long, one that is rich in a variety of experiences, one that brings pleasure? When a physician says to a patient, "Slow down. Don't work so hard. Take time to smell the roses and you'll live longer," the admonition makes a statement about what is valuable in human life. Ironically, the statement expresses a value which physicians often find difficult to implement in their own behavior.

The dominant value in recent centuries in western medicine has been that of beneficence. "Beneficence" means "doing what is good for another, acting in the other's best interest." Beneficence in its best sense represents a concern and commitment to another human being. The caring physician, much prized by patients in our society, is the physician acting beneficiently. There is an element of self-sacrifice in the notion of beneficience: the physician will do what is best for the patient even in the face of the patient's failure to cooperate or comply, even if the patient is not clean and doesn't smell good, even if the patient requires care in the middle of the night or on a weekend, and even if the patient

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is ungrateful. A professional ethic based on beneficence contains much we, as a society, have come to admire. Physicians have justifiably taken pride in the commitment to others that the ethic of beneficence dictates.

Yet in recent decades, beneficence as the sole base for medical ethics has come under increasing criticism. Since World War II, concern for individualism has increased greatly in American society. People have become conscious of rights they never knew they had before. Participative decision making has become prized as a model for behavior in families, groups, and organizations. Submission to, and some would say respect for, authority has declined. In our consumer society the rapid differentiation of products and services to meet differing individual tastes has dramatized the rise of individualism. In the media we have gone from a nation with a relatively small number of large circulation magazines such as *Saturday Evening Post* and *Colliers* to a nation of many magazines targeted to specific audiences like runners, audiophiles, and rock hounds. Even health magazines have proliferated. This same pattern has repeated itself in radio and, through cable, is rapidly developing in television. The consumerism movement also reflects rising individualism.

Concern for individualism has driven much of the effort in bioethics in the last 15 years. Beneficence has been portrayed as "paternalism." The physician

deciding in the patient's best interest thus becomes, not a self-sacrificial, caring individual, but an autocrat who would substitute the doctor's judgment for the patient's wishes.

The principle of autonomy has been juxtaposed to this paternalism. The idea of autonomy is grounded on the writings of such philosophers as Immanuel Kant as well as on the concept of individual freedom built into American society. One should respect the autonomy of another individual because personhood is an end in itself, not a means to some other end. How can freedom be meaningful, if another, even a physician, can control what happens to one's own body? Here the legal position regarding consent to treatment has been an ally of those who would stress autonomy. The addition of information to the notion of consent has buttressed the individualistic position toward medical ethics.

This change in values has not been welcomed by all physicians. Taking time to give information and to get consent forms signed has at times made the practice of medicine seem more complex, more bureaucratic, and more legalistic. The resentment by physicians is more strongly grounded, however. Argument for change has too often been phrased as an attack on the medical profession itself. Physicians who have thought themselves to be acting self-sacrificially in the best interests of patients have been portrayed as undermining human freedom. Redefining the traditional value of beneficence as paternalism that undermines freedom may seem to distort the very value through which physicians have regarded themselves as a "good" profession. Medicine has seen itself as different from business and law precisely because its ethical base was stronger. With that base under attack, it is not surprising that a number of physicians have resented the attackers.

While some of the criticism of medicine has come from the consumer movement, another primary source has been bioethics. Bioethicists most often come from the fields of philosophy and religion. They have established themselves as commentators upon and critics of the practice of medicine. While a number of physicians have joined the ranks of bioethics, it has been primarily a self-styled movement developed outside of medicine and purporting to speak for patients in particular and society in general. Technological innovation, resource scarcity, and virtually any other reason has been used by bioethicists to justify a role for themselves in decisions about American medicine. And they have been successful. A major presidential commission produced volumes of work on bioethical issues. Bioethicists are now called upon by the media to comment on important bioethical issues. Bioethicists have found their way onto the faculty of the majority of medical schools in the country and courses in bioethics are often found in the catalogues of undergraduate educational institutions.

Again, the presence of these "outsiders" commenting on the way doctors do their work has not been entirely welcome. Physicians had not organized themselves to criticize philosophers. What were philosophers doing criticizing doctors?

A number of themes have characterized physician resistance to the bioethics movement. Four predominate:

1. "Medicine has always been a strongly ethical profession. There's no need for anyone outside of medicine to be involved. Doctors are strongly ethical. We can take care of our own profession."

2. "You can't learn ethics in medical school. You learn to be ethical at your mother's knee or at least at the foot of your first attending. People are either ethical or not and you can't change that by reading a lot of philosophy."

3. "You ethicists can never agree. There's always some argument to be made from every point of view. There's no way to choose. What you believe doesn't matter as long as you have your own beliefs and know what they are."

4. "I've read a lot of what you ethicists have written. It all sounds good, but when I'm faced with a decision as to whether to shut off a life support system or to continue to treat a seriously ill newborn, all that abstract theory doesn't mean a thing. Bioethics doesn't do anything for me in practice. It doesn't help with what I have to decide."

Each of the objections has some merit. As indicated previously, medicine has always had a strong ethical commitment and character is, in part, formed in early training both in the family and in the profession. But the latter two objections have considerably more force. If the consideration of ethics in medicine doesn't allow us to differentiate among possible actions and, even more importantly, if it makes a difference only in theory and not in experience then it would seem to warrant little attention. I shall consider the basis for these objections and then attempt to explain a way of using ethics that can make a difference in experience.

Principles • There are three important questions that the study of ethics can ask:

1. The Question of Principles: What is the "right" (or wrong) thing to do?

2. The Question of Values: What goals are worth pursuing?

3. The Question of Virtues: What does it mean to be a "good" person (doctor)?

Each of these questions directs our attention

somewhat differently. Philosophers studying ethics have devoted themselves primarily to the question of principles. What is right and wrong?

The study of principled ethics attempts to develop a code of principles that can guide actions so as to make them ethical. Such a code, if fully developed, would be:

1. General. It would apply to a wide range if not all experiences.
2. Impersonal. It would apply to all persons and not be individually variable.
3. Abstract. It would be phrased in abstract rather than concrete terms in order to generalize over a wide range of circumstances.

Principles having these characteristics would then be applied to specific cases through the use of deduction. Argument would be tested through the rules of logic and would require considerable attention to definition of terms and precise use of language.

Because principles can conflict, it is necessary to develop a method for choosing among principles. A hierarchy of principles will be needed to indicate where some take precedence over others.

The method for clarifying and choosing among principles is to address hard cases, cases in which the principles are juxtaposed most dramatically. These cases are of necessity unusual rather than usual and are often quandaries, even dilemmas. One of the basic means of developing a set of ethical principles has been careful consideration of the most extreme, unusual, and difficult ethical cases. In considering the right of a patient to refuse treatment, for example, consideration is often given to the case of Donald C., a victim of extensive burns who wanted to refuse treatment and be allowed to die, but was unable to stop the treatment given to him. The conflict between subjects' right to withdraw from biomedical experiments and the prohibition on physicians against aiding suicide is examined by debating the wisdom of providing a switch so that Barney Clarke could turn off his artificial heart. In considering the wisdom of surrogate parenting, we are asked to consider the possibility that poor, ignorant women from underdeveloped countries may be effectively enslaved as brood mares. Such difficult cases may be interesting to debate but they do not characterize the ordinary ongoing life of physicians and patients. Developing an ethic primarily through consideration of such extreme cases may seem destined at the outset to miss the problems in ordinary medical practice.

There are other problems with the principled approach to ethics. While principles are general and abstract, experience is concrete and specific. It is not always easy to see how an abstract code can be applied. Often more than one principle seems applicable and it is hard to know how to choose between those. This feeds the criticism that all views are equally good.

When expressed in principles, ideals tend to be polarized. We seem forced to choose between two principles when we want to embrace them both. We may be asked to choose between patient autonomy and physician beneficence when we believe that both are important. We are asked to choose between life and choice and between education about the value of chastity and about the protection of condoms. The question, "Who should decide about treatment, the doctor or the patient?" is the wrong question. The better question is "How can patients and doctors decide together?" But the dilemma nature of the consideration of principled ethics juxtaposes principles in order to decide between them. This practice forces us into choices when we might prefer to rephrase the questions to avoid such choices.

Since principles tell us what is right and wrong, they do not easily lend themselves to compromise. How can we compromise what is right? Yet, in working together, human beings must often devise compromises with which all can live.

Because the cases through which the system of principles is developed are extreme cases, it is hard to draw on those cases as examples when one is faced with ordinary experience.

Ethical principles are both developed and applied through the application of systematic logic. The argument is rational; no emotion is to be admitted. Yet we know in our ordinary observation of people engaged in coversations about ethical issues that ethics is indeed a matter for emotion. When the very meaning of human life is being considered, when the appropriate role one should play in society is under examination, and when questions of how we ought to be to each other are being discussed, more than our cognitive systems are engaged. Our whole beings are involved. Many of us have been striving to find a way of thinking about medicine which admits emotion as an important element. Is it reasonable that a theory of ethics for medicine should exclude emotion at a time when we are increasingly attending to the role of patient emotions in illness and physician emotions as they influence the way patients are treated?

Similarly, the abstract nature of principles means that they apply equally to every one yet much recent concern has focused on making medicine a person-centered activity. In cliche form this becomes "Treat the patient, not the disease." We want a theory of medicine that starts with the individual. Those of us who sometimes describe modern medicine as scientific and overly technical should find it difficult to embrace an ethic for medicine that excludes individual considerations from the ethical system.

Principled ethics, because they are concerned with what is right and wrong, focus on rights and duties. They tell us what we are obligated to do for others and what we are entitled to expect from them. Yet some of the elements we want in an ethic for

medicine seem poorly described as either rights or duties. Does one have a right to be loved? Can caring come from a duty? Doesn't describing compassion or fairness as obligations rob them of their very essence? If they come not from free choice but from duty can they have the force we desire?

Finally, if our effort is to find a set of principles that can apply to all in our society, we may find the task impossible in a society characterized by pluralism. We have come to prize and even celebrate the opportunity to exercise difference in belief and value. How, then, can we hope to find a set of principles which can apply to everyone in a society? Yet a system of principles which does not apply to everyone again invites the criticism that all views are equally valid, and the system of ethics turns out to be no guide at all.

The primary approach of bioethicists whose training is grounded in philosophy has been the approach they learned to apply to other ethical issues. They have attempted to develop a principled ethics for biomedicine. Yet that effort, while useful in part, has made many doctors reject the whole consideration of ethics in medicine. Bioethics has given insufficient guidance because it often seems impossible to choose between competing principles and finding a way to apply those principles in the confusion of everyday experience. Physicians who have wanted to consider the ethical aspects of medicine and who have looked to bioethics for help have, because of the over emphasis on the question of principle, often not found as much that is useful as they had hoped. They might find more assistance by considering the second and third questions, "What goals are worthy?" and "What does it mean to be a good doctor?" Note that these questions do not answer the question of what is right they simply turn our attention to other issues. No one would argue that the question of principle is unimportant, but if addressing it does not seem to help with experience, we want to give more attention to the other two questions.

Goals • The question of values asks about goals. Toward what end should we direct our activity? What purposes, objectives and ends should be the focus of what we want to obtain at various levels of health care from the system itself to individual practice? The primary goals will vary but would include good care, person-centered care, and efficient care whether related to time and energy or involving cost control.

While principles are either right or wrong, goals allow for degrees of accomplishment. In striving to be efficient, we may have attained some success but may want to strive for an even greater degree of efficiency. Further, we are not forced to choose between different goals, but may instead balance our efforts. We may direct some energy toward efficiency and some toward being supportive of other persons. In reviewing our performance we may decide that in one case we emphasized efficiency too much and personal sensitivity too little or vice versa. The guide for future acts is the attempt to attain the appropriate balance in goal pursuit. Asking the question of values allows us to achieve partial success in balancing conflicting goals to achieve the most desirable set of acts.

The question of values inherently facilitates compromise. It does not trap us into thinking we must choose between goals but allows us to compromise in order to strike the balance between them. Under different contextual pressures, we may decide to pursue one goal for a time more intensely than another. If, for example, there is a temporary budget shortfall, cost efficiency may become a goal with a higher priority than at a time when the budget is more ample.

The balancing of goals also seems a good fit with the uncertainty and ambiguity that characterize medicine. Any decision method used by physicians must allow for the presence of uncertainty in diagnostics and therapeutics. It is equally true in the areas of values and ethics. Here the standard of doing one's best applies. One need not worry that one has done the morally wrong thing because one is not asking the principled question. Rather one does the best one can to achieve what seem to be the most appropriate goals given the level of certainty present. Morality from the point of view of values and goals consists not in being right, but in an effort to engage the ethical issues. The only immoral act would be the failure to struggle with the ethical questions. Past experience becomes a basis for reexamination and the attempt to achieve a better balance in the future, not the search for moral error. Ethical life does not consist of finding a set of right answers which will settle the issues once and for all. It features the struggle to balance competing values as best one can in the short run and the constant reexamination of the value question.

Virtues • The first ethical question we can ask is the principled question, "What is right and what is wrong?" The second question we can ask is the value question, "What goals are worth pursuing?" The third question is the question of virtue. What does it mean to be a "good person," "good doctor?" This question is much like the question of value. Rather than directing attention to the health care system, the hospital or an individual practice, the question is addressed to the individual's character. Hard work is a virtue. Compassion is a virtue. Self-preservation is a virtue. Scientific and technical competence is a virtue. The question of virtue ethics asks how the physician should manifest the virtues associated with the profession in character and behavior.

Here again the answer lies in degrees of accomplishment and balance. One does not either have or not have compassion, but one is able to manifest it in differing degrees under different conditions. In reviewing one's own ethical life, one might decide that more attention to compassion is warranted in the

future. The virtue of self-preservation is often undervalued by physicians. The high rates of personal failure, substance abuse, divorce, and suicide indicate that a number of physicians who may well exhibit the virtues of commitment, hard work, and dedication to patients, fail sufficiently to stress the virtue of self-preservation. They may have spent too little time pursuing their own self-development or attending to the needs of their families. A good person, a good physician, is also a balanced human being who attends to his own needs as well as to those of his patients. While self-sacrifice may be a virtue, if too much of the self is sacrificed too often, too little of the self will remain to share with others in the future.

It is not necessary to list all the possible virtues here. Honesty, truthfulness, fidelity, courage, respect for patients, keeping secrets (confidentiality), and those listed previously are a good beginning. Both the American Board of Internal Medicine and the American Board of Pediatrics now include certain virtues as necessary standards in the characters of residents completing accredited programs.

Stories ● The argument above, then, suggests that pursuing the questions of values and virtues may be a more useful basis for ethics in medicine then limiting study to the question of principle. The problem remains, however, "How does one 'do' medical ethics?" At least the principled approach offers us the logical test for our arguments. How would one "do" values and virtues?

Here the humanities disciplines offer an alternative. That alternative stems not from philosophy as does logic but from history and literature. Scholars in the humanities refer to it as narrative theory. Narrative theory is enjoying particular popularity in all those disciplines which study discourse. The fundamental assumption of narrative theory is that the telling of stories to one another is among the most basic of human activities. One author even names man *homo-narrans*, man the story teller. It is through the telling of stories about ourselves and the events around us that we define reality, explain who we are to one another and set the stage for future action. Story telling makes sense out of our lives and out of the world. As we listen to the stories others tell us we learn what is important to them, what they believe is memorable, who in their stories is what kind of person, and what kinds of values justify decisions and actions.

Stories do not relate the facts of the matter but, rather, the perceptions of the story teller. Stories, therefore, are importantly interpretative. They are symbolic constructs. They select from all events those which are to be figure and those which are to be ground. The people who are portrayed as leading characters may differ when different story tellers tell about the same set of events. The actions which seem justified and unjustified may differ. The consequences of acts may be portrayed differently.

Because stories are interpretative, they tell us about the story teller as much or more as they tell about the events in the story. Hence, we can say that stories reveal what are taken to be values and virtues by those who tell stories. These become the underlying premises on which interpretations are based and on which actions are justified. As listeners to stories, we often must interpret in order to discover the values and virtues that are the underlying assumptions by story tellers. These are seldom expressed explicitly.

As we listen to the stories which others tell us, we will discover that they have structure. Time passes and characters appear. These characters have roles. Some are good guys; some are bad guys. There are heroes; there are villians. There are characters whose role is apparently comic relief. A plot unfolds in the stories we hear. There is action. There are major events, and there are minor events. There are climactic events. There may be an anticlimax. A mood is created. The mood may be tragic, heroic or comic. Sanctions are applied to the story. Some events or characters are depicted in a positive fashion while others are depicted in a negative fashion. The positiveness and negativeness tell us what the story teller values. Stories have a point of view, a perspective, a narrative stance. As we hear the story, we become aware of the narrative stance or perspective of the story teller.

Stories also imply the future. When one hears the past events as portrayed by the story teller, one knows that only a certain number of future events are possible. The person whose story depicts continuing success implies that the future is likely to bring still more success. The person at the end of his rope, experiencing constant failure, will find it hard to envision a dramatic turn of events leading to success. A patient depicted as incurably ill may seem one for whom limited treatment may be justified. If the illness is portrayed as episodic, extensive treatment designed to cure may be justified. Because stories imply the future, story telling leads us to decisions. As we work together, we tell one another our stories of the events we are encountering. When the stories we share come to imply similar next episodes, those next episodes become our decisions.

When we tell stories to one another, we discover the differences in our stories and have the opportunity to clarify them. Often we will modify our stories on the basis of what we have heard from others. Our stories will become more alike and, hence, make an agreed-upon decision more likely. Stories work not by argument but by suggestion and by identification. We identify with the character in the story. We feel with certain characters. We accept the suggestion as to what things are like and on the basis of that definition of reality confront the possibilities which such a depiction presents. We will not find the kind of logical arguments in stories we find in philosophical disputation or debate.

Stories capture the experience of the world. We carry in our heads what might be called archetypical stories. Stories we hear and experience are matched against those patterns. What is true for the archetype will be assumed to be true for the story which fits it.

Analogical reasoning ● The preceding descriptions of the stories we tell each other may seem accurate, but they may not seem, on first examination, to inform us how to do medical ethics. Narrative does bring with it a technology which differs from the deductive logic of principled ethics. The logic of narrative is not deduction; it is analogy. Analogy is simply the making of comparisons. A patient may say, "I don't want to hook my mother up to the respirator because when we did that to my uncle we had trouble deciding when to turn it off." Here the story of the uncle and the story of the mother are matched by the story teller and found to be similar. The listener will ask the question of whether or not important similarity does indeed exist. Were the medical circumstances surrounding the uncle similar to those surrounding the case of the mother? If so, the analogy may be apt and provide a good basis for decision. But if the situations are not similar in their essential respects or if there are other analogies available which better fit the case, then we may want to reject the story of the uncle as the basis for determining the next episode of the mother's story.

Another way of looking at this process of comparison is as if we have templates which match certain life circumstances. The template metaphor has been used to describe the diagnostic process in medicine. A similar kind of analogical reasoning exists as we examine narratives. Since narrative works through analogy or comparison we can judge the quality of the story by examining the quality of the analogy.

Stories are shared. We talk to each other about our experiences. As people share stories with one another and the stories are retold, some elements in the stories triumph and persist while others drop out. Still others are integrated with other elements into the overall story. The stories which persist in retelling are good stories. They are good stories if they fit the facts. A physician can improve stories by pointing out where the facts of the stories do not fit the medical facts. Imagine that adult children tell a story of their mother who has a case of incurable Alzheimer's disease, but the medical facts, as determined by the physician, point only to a temporary nutritional difficulty. The children's view of the next episode in the life of the mother will change dramatically once the story is told with the appropriate medical facts.

Good stories are more complete than poor ones. They account for more detail. Good stories are internally consistent. They are also consistent with the events exterior to the story itself, but involving the same context or characters. Good stories have a kind of organic consistency we can call coherence. They hang together. There is a unity. They seem to be all of a piece. Good stories focus on the shared values among the various story tellers. The story becomes acceptable because the values in the story are shared.

Good stories fit our experiences. Occasionally, when someone tells us a story of something that has happened in his life, we shake our heads and say, "That can't be. The world as I know it doesn't work that way." Good stories, on the other hand, make sense. They seem reasonable. They seem to fit the world as we understand it and the way it works. We use narrative, then, to understand the nature of the story we tell and of the stories told by others.

As we listen to stories, we learn how the story tellers see the people who are involved. We find which characters are fully developed and what traits are portrayed as positive. We learn what futures are implied by the plot, what events are seen as climactic, and what events are considered trivial and unimportant. We learn how the narrator sees himself or herself by the perspective from which the story is told.

Having listened for the key elements of the story, we are then in a position to interpret the story. We ask what are the fundamental values that form the spine of the story. What are assumed to be the facts? Once the physician has identified the values and the facts as expressed in the story, the story telling can then be used to help patients and families. Where the stories do not fit the facts, physicians can retell the stories emphasizing the medical facts as the physician knows them. Where the stories are not good analogies, where the comparisons are not apt, the physician may tell another story which makes a better comparison and is a better analogy.

Physicians can help patients and families by encouraging them to tell their stories and by encouraging them to elaborate the characters and the plot. Stories are usually told in an abbreviated form as in the case of the mother and the uncle above. "Tell me more about your uncle's problems," the physician may say. By listening for the elaboration of the characters and the plots, the physician will be able to identify whether or not the comparison is a good one, and the physician will learn much more about the story teller. Where elements in the story have been treated in a cursory fashion, the physician can encourage the elaboration of those elements. The physician can then feed back key story elements to the story teller to see if those elements fit the way the story teller really wants to see the world.

Finally, the physician can use the narrative technique to help in the making of decisions. The physician may encourage those in the health care team, family members, and patients to tell stories about the critical events to each other. By interpreting together what the stories mean for each, it may be possible for all those involved to come to a collective

interpretation which is acceptable. The alert physician may also be able to offer stories which imply future actions that all can accept.

The following list can serve as a summary of how physicians can use narrative to help address ethical problems:

1. Understand your own story. How do you see the characters and events? What future does your story imply? What values does it reveal? What are virtues in the characters?

2. Encourage others involved to tell you their stories. Understand patients, family members, and other care givers perceptions and values by listening to their stories. Interpret their stories as you did your own.

3. Encourage the elaboration of key events and characters to make stories more complete and revealing.

4. Clarify facts in the stories where they are inaccurate or unclear.

5. Examine analogies for the appropriateness of the comparisons. Offer alternative analogies where appropriate.

6. Encourage the elaboration of future episodes implied by the stories told. Note where different and similar futures are implied by different stories.

7. Encourage those involved to share stories and to pool their stories toward accuracy, completeness, coherence, unity, and a good fit with experience.

8. Offer alternative future episodes where appropriate.

9. Develop a story which integrates the values of those involved, implies an acceptable future, and guides actions.

To illustrate the usefulness of narrative in medical ethics, let me tell two stories: The first is about a medical student who was assigned to follow a patient hospitalized with pneumonia. The patient was also suffering from AIDS. Only the patient's wife knew that he was bisexual and that he had AIDS. The patient came from a large, close-knit Latin family. His father was greatly concerned for the well being of his son. On several occasions, the father talked directly to the medical student asking, "How is my son?" The medical student felt uncomfortable. He knew that simply saying the son seemed to be recovering from the pneumonia was not really a truthful answer to the question. At the same time, he felt constrained from revealing to the father that the son had AIDS and was bisexual.

When the medical student presented this difficulty to his preceptors, they could easily have treated it as a dilemma of conflicting principles, the principle of confidentiality on the one hand and the principle of veracity on the other. Should one keep a secret or tell the truth? The ethicist and physician who worked with the student, however, chose not to opt for a philosophical debate among principles. Instead, they advised the student to see himself as a character in this story, a character affected by his own perceptions of values and faced with a value quandary. They encouraged the student to share with the patient the role he was playing in the story.

The student did that. He told the patient that he was having difficulty knowing what to say to the patient's father and wondered if the patient could talk with him a little bit about what he really wanted. As a result of that conversation, the patient began to see the implication of his current desire for secrecy for the longer term future of himself and his family. He began to realize that at some point his family would need to know, accept and understand his illness and lifestyle and that bringing his life to a good end would require at some point the confronting of these issues. He reconstructed the story and saw himself sharing this information with his family as an act of love and reaffirmation. The patient was then able to act on that future as he had come to conceive it.

Rather than asking which principle was paramount, the medical student asked about values and virtues. By using the narrative approach he enabled both himself and his patient to discover alternative futures which made resolving an apparent dilemma unnecessary.

My second story is that of a couple who had been lovingly married for many years. When the husband developed terminal cancer he confided in his physician that his strong love for his wife made him want to limit treatments which would leave him weak, emaciated, and supported by tubes. He wanted his wife to remember him as he had always been: energetic, strong and vigorous, able to provide her with humor, support, and understanding.

The wife spoke separately to the physician, stressing her long and deep love for her husband. As she envisioned the future, she told her story of how it would be. She wanted the physician to do everything possible to prolong the life of her husband so that they might share as much time together as possible. She was more than willing to care for him in every personal way in order to sustain his life and to share as many moments with him as she could.

The future she saw in their story of love was one of the maximum possible time together. The value underlying his vision of the next episode in their story was one of strength and consistency. Each story was based on love. Each episode was plausible. Each sought to implement values the physician could admire. What role could the physician play?

If one asks the principled question, "Who

should decide, the patient or the patient's family?'' the principle of autonomy makes the answer quite clear. The physician should attend to the wishes of the patient and not to those of the family. Yet family members are importantly involved in the stories of their loved one's illnesses. They hope. They fear. They hurt. They cry. The wife's concerns were good ones; the goals she sought to serve were positive goals. Simply ignoring them didn't fit the character the physician saw himself playing nor was it consistent with the patient's regard for his wife.

The physician told his story to the two of them, the story of a man trying to assist both of them to realize the best future. He then got them to tell their stories to each other. Each recognized the story of the other as an act of love. Taking the medical facts as related in the story of the doctor into account, they were able to integrate their stories of the future. The husband agreed not to leave his wife too soon and not to seem to abandon her. The wife, at the same time, recognized his need to remain, in her eyes, the man he had always been. He accepted her need to have him there, and she accepted his need not be remembered as weak and dependent. They, along with the physician, were able to agree on just how much and what kind of treatment would be used. A story was created which could integrate the values and facts held by all three.

Cases • If increased concern for bioethics has been accepted only reluctantly by many physicians, it may be because the question of principled ethics appears to constitute an attack on long-held physician values, on the one hand, and to offer little direct assistance in day-to-day experience on the other. Realizing that the question of principle is not the only ethical question may enable the profession to broaden its view of the usefulness of ethical consideration. Directing attention to questions of values and virtues may be fruitful. Such attention may be particularly helpful if the role of story telling in human life and decision-making can be recognized, and if physicians can become proficient in using the stories to assist them in meeting the ethical demands of situations.

The case has long been the method of sharing ideas about medicine. The case is, after all, a story. Often, cases shared by physicians portray the values of diagnostic insight and therapeutic creativity. They seem to emphasize scientific findings and technologically sophisticated tests. Recognizing that these cases may be elaborated to become stories which portray patients' values, hopes, fears, and visions of the future may supply a technique that will also assist physicians to deal with ethical problems that they must face.

Sometimes we wonder why novels, short stories, and biographies speak to us so profoundly about our experiences. We may feel deeply informed about some part of life as we leave a play or film. The impact of fictional accounts comes from the authors' or artists' careful portrayals that highlight and dramatize the value issues surrounding characters and events. The stories then serve as parables, moral guides. If we learn to see ourselves and others as involved in the same kinds of stories, we may be able to develop similarly powerful insights into the real people and events with whom we must deal.

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The challenge of the ethical life in medicine

Reverend Vincent T. Kelly

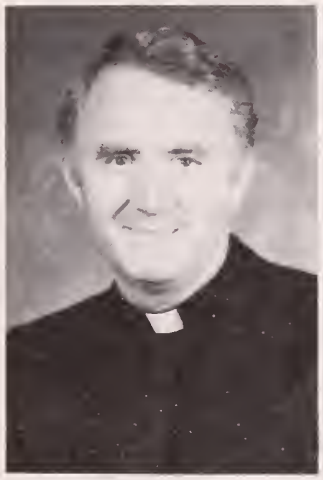
As a member of the clergy, I am awed by the invitation to offer pastoral reflections to members of the Florida Medical Association. I evaded this challenge because medical ethics is a specialty field and I felt somewhat inadequate. However, I succumbed to the persistence of Dr. James Perry when he convinced me that what physicians needed was a pastoral dimension to their work as much as a biomedical challenge.

To understand what I write and why I write it, I wish to give you very briefly three elements in my background which are influential:

1. **Veterinary profession:** My father and grandfather were veterinarians. I, too, planned to be a vet and was accepted in veterinary school. The veterinary profession in those days was the James Herriot vintage, "All creatures great and small." The style of relating to the owners of the animals was very personal. I, as it were, changed horses and made a decision to enter the seminary.

2. **Priesthood:** It is difficult to understand Priesthood in today's world. To some, it is an anomaly and lacks reverence; to others, it is a sign of hope for the present as well as the future. It provides a healthy respect for our world while being ready to challenge and attempt to excise what is not healthy. In a very human way, it attempts to bring mankind to God and God to mankind.

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3. **Field of education:** I had desired to be a simple parish priest, the type you may have read about in times past. Life was not to be that easy. I was assigned to education 30 years and, as of today, I am still in administration with the Office of Education of the Archdiocese of Miami.

If you can keep these three backgrounds in mind, you may understand more clearly my observations. I submit my remarks with great respect for an illustrious profession. I do so also with some awe for the exalted position you hold in society. I offer my continuous appreciation to all of you and your confreres for the diligent assistance all of us out there have received. A certain feeling of trepidation however cautions me that I may be stepping out of my field. But in much of my life, I have been known to throw caution to the wind so I have decided to offer you some provocative observations.

Priest and doctor • All of us in the human species have two parts, a body, which is the beautiful creation of the Almighty, and a soul, which we designate as the life-giving principle. It is the soul, the invisible power within one, that is spiritual and eternal. In this precious component is contained the basis for life, which makes us a reflection of God. You have heard of the Latin axiom, "Mens Sana in Corpore Sano" (Sane Mind in a Healthy Body). We must address the comprehensiveness of humankind—the total being. Any lasting impact on one element must consider the

other. Thus, professions dealing with one aspect of the human mystery must be sensitive to and totally cooperative with the other agencies which touch on the totality of the individual. Consider for the moment two distinct sciences and explore how interrelated they really are: Theology and Medical Science. Rather, let's take the persons involved in these sciences, the priest and the doctor. Both are sacred callings, they provide service, they offer healing. They involve rigid training as well as constant upgrading. A survival mechanism must be fashioned so that participants do not burn out and become ineffective. A tremendous amount of cooperation is necessary for maximum results. In both, the human delivery system is very important where warmth, compassion and personalization are so essential for maximum results.

There are obvious differences of which each discipline is well aware and both can learn from each others' experiences. Looking at all the mistakes we, the clergy, have made over the years, your group may avoid some of the following pitfalls:

1. Within the Church, we have seen the religious who is so professional that he has adopted a "holier-than-thou" attitude and in the process neutralizes his impact on people. He represents the least desirable image of the Church.

2. We have at times over-organized our religious structure and frequently are too busy completing projects while not giving enough time to people's spiritual needs.

3. Unfortunately, every organization of length is liable to misguided leadership. We have had our share in the Church over the years.

4. Periodically, in time, we have strayed from our original intents and need to be challenged to return to the essentials.

5. Too often, we lost sight of the need for humanness—that we deal with imperfect human beings and must, therefore, be understanding, compassionate and forgiving.

For thousands of years, religious leaders have enjoyed much success sometimes in spite of their human failings. Obviously, the Lord is minding the store. A story about the French Court at the time of Napoleon may illustrate the point. Napoleon was displeased with the way the Church was cooperating with his government. He advised Cardinal Richelieu that if he did not cooperate, he would destroy the Church. The Cardinal replied, "We priests have been destroying the Church for 2,000 years and we haven't succeeded."

Look at the impact of the clergy all through history. They have been responsible for calming the seas as well as fomenting high emotion. Take the example of the religious fanaticism caused by the mullahs in Iran today. In the name of Islam, they are radicalizing an entire nation and not only one nation but potentially the entire Middle East. Western civilization, which has become substantially secular, is unable to understand such religious motivation. Fortunately over the centuries, the influence of the clergy in almost all cases has been balanced, positive and constructive.

Can we both learn from our mistakes? Can you avoid the five pitfalls previously mentioned? Please consider them in your profession.

1. Have some medical practitioners become so professional that they have moved to a status of "untouchable" like the holier-than-thou clergy? By a domineering attitude, they are feared more than respected and lose much of their effectiveness.

2. Are you being over-organized to the point where you are being severly inhibited and personal initiative is restrained?

3. Is the leadership of your group at the local and national levels always giving proper direction?

4. Are some of you straying from your vocation and need to be challenged to redirect your course?

5. Are you basically persons who are sensitive to human weaknesses and desire to assist where possible? Is compassion a symbol of your profession?

We can all learn from the mistakes of the past if we are open. You might consider then the most fundamental question that can be asked of you. Why are you a doctor today? More than likely the motivation varies because of your disposition, family, background, experiences in youth, natural talent, association with healing, ambition, willingness to work and sacrifice, and educational background. In our occupation, it is healthy to look introspectively and ask periodically, why am I a priest? Why am I doing what I do? Is it perfunctory? Is my idealism still there? Am I straying from my goal? Do I need recharging? You might ask yourself now: Why am I a doctor? Is it:

1. to help mankind?
2. to make people feel good?
3. to practice medicine?
4. to cure ailments?
5. it offers personal fulfillment?
6. just a job?
7. to only provide for my family?
8. to make large amounts of money?
9. just a vocation I selected in life?

More than likely your motivation reflects a mix of these categories. Look at your profession historically.

a. In olden times, the doctor brought confidence. His very presence in the rural type setting gave everybody assurance that things would be all right. "Our doctor is here, no worries." The practice of medicine was most personal. In many respect, it was an easy way of life and suitable for the time.

b. Olden times gave way to new structures, new demands. Medical research has made tremendous strides to benefit mankind. In the process, it has changed the total approach to medical practice. Even the computer-age mentality has invaded the profession and brought along its impersonal responses. Unfortunately, some of the old-fashioned confidence has eroded with the demise of the General Practitioner era.

What makes life difficult • So many agencies or factors today generally prevent that individualized approach of yesteryear and make it difficult for you to do what you can do best. Take a look at what makes life difficult for you:

1. **Society's pressures** • The fast pace of living and the high expectancy level of performance that is always demanded of professionals. Unfortunately, the ones must subjected to this pressure are the conscientious.

2. **Commercialism** • The business industry, in its quest for greater profits, may exert pressure on your profession to absorb new equipment, medicines, etc. The name-of-the-game for business is increased sales. You may be influenced to adopt the same tactic.

3. **Competition** • Competition from your peers is becoming an issue, from an ever-increasing number of medical school graduates, both domestic and foreign, as well as organized medical groups such as the Mayo and Cleveland Clinics which recently have taken a liking to Florida. The turf of the established practitioner is under attack.

4. The cost of doing business today where increasing staffs, updated equipment and sophisticated techniques keep the pressure on you to pay the bills.

5. The excesses of insurance coverage and the constant shadow of frivolous malpractice suits, consciously or unconsciously, make you more cautious and gun shy. We are all aware that there is risk in all of life; without risk, there is no life. Be consoled, however, you are not the only ones subjected to this extreme. Both the clergy and educators have also become fair game for liability. This trend is just reflective of a contentious society.

6. Family relationships which we could take for granted in more stable times now demand much more attention. If our medical families are to remain cohesive units, they need more of our diminishing time. Time with the family may require a change of workaholic attitude, but it begets compassion.

7. The changing mores of contemporary society, where sexual promiscuity, alcohol and drug abuse have become commonplace, put great pressure on the individual to compromise. Any one will have difficulty just keeping a balanced mentality.

8. The final pressure I would like to address is the on-going growth of one's professional career and personal interpretation of service. Your own ambitions may set the seed of dissatisfaction which you will have to address sooner or later.

There may be other issues that subtly place pressure upon you. Only you would know what they are. The question you can now ask yourselves is: Do you permit such outside forces to dictate your professional career and change you into the assembly-line mold of physician or is it within your power to protect yourself against hostile takeovers by elements alien to your occupation? Will you wait to be consumed or will you rekindle your old-fashioned idealism? You, as a group, must take hold of your destiny. It seems you must develop a collegial mentality amongst your confreres and other allied health care occupations. When you have reasonable unity, you can establish what is best for all and how medicine can provide service to the people of our land. Wait too long and a chaotic version of socialized medicine may be inflicted upon you. This, incidentally, is not a political rallying point. It is simply a challenge to get your own house in order and protect your collegial profession. Well-intentioned politicians formulate legislation; however, in many cases the information available to structure balanced law-making is most inadequate. You, as a collegial group, must have more influence in developing the health policies of our nation. If you do not, others lesser informed and lesser committed to health care will impose their will upon you.

All professional agencies should have an objective group to plan direction. Some members who are philosophically inclined to look to the future should meet regularly to be creative, such as we see happening in some thinktanks. Normally, we are operatives, reacting to the daily crises. We are not able to address the unknown. We need objective stablization and planning. Every profession needs it, every Church needs it. Even our national government might do well with it. In addition to the three major branches of our federal government, executive, legislative and judicial,

we might consider having a fourth unit, a constitutional level which will call all the others back to their origins. Your medical association needs to challenge each of you to your origins to be the best and most responsible physician possible.

Observations ● If I may indulge a few more moments of your time, I wish to summarize some of the provocative challenges I have referred to previously. Please keep in mind, as I have indicated already, that we clergy have made most of the mistakes possible in life. We would like to assist you in not repeating such mistakes. These observation may stimulate some conversation at a later date, but they can also serve as a "Physician's Examination of Conscience."

1. Why are you a doctor today? Is it purely altruistic reasons or is it in the service of your fellow men and women?

2. What is the primary fulfillment you seek in the practice of medicine? Are any of the nine classifications previously listed in your personal plan?

3. Have you always been faithful to the Hippocratic Oath or has your original promise to give yourself in total service been gradually withdrawn?

4. Do you see the dignity of each human person you attend or have the numbers and the pressures blurred your appreciation for the gift of the individual? Perhaps as a specialist, eyes, ears, nose or throat or even the "end-all" of proctology have become your narrow world? Or, do you see a person with hopes and fears, with emotional ups and downs, with human weaknesses and strengths, a person, yes?

5. Do you see a purpose in your own life? Will accomplishing that purpose lead you somewhere? Lead you to an eternal reward?

6. Do you feel proud to be a member of the medical fraternity/sorority, even when occasional blemishes are sensationalized in front page news stories? Are you totally supportive of the profession?

7. Do you see your colleagues as associates in ministry or are they competitors to be knocked at every occasion? "Collegial" emphasis must be developed in all of you.

8. Do you take care of your own health and consider the dictum, " Physician heal thyself," or would you rather pluck the speck from your brother's eye while the beam is in your own?

9. Are you beyond suggestion or even correction or is that for other mortals?

10. Do you continue to upgrade yourself as a changing profession would demand or are you satisfied in your present level of intellectual attainment?

11. Do you restrain your material appetite or does the acquisition of things, power or money control your every decision?

12. Do you consider your spouse as a partner in your ministry of service, sharing your life, or is the "doctor's wife" an occupation of its own? Are your children a part of your plan or do they interfere with your practice of medicine?

13. Do you believe in a support system where select persons become reliable confidants and can mirror your thoughts without fear of offense? Are you comfortable sounding out new ideas with others?

14. Do you realize the power of the medical profession to influence, that each doctor has a voluntary constituency which when grouped with all other doctors' patients comprise almost all of the electorate of the state?

15. In your overall willingness to serve, do you have a tender spot for the indigent and elderly? Are you willing to take up the cause of the elderly in a society that appears to neglect them? The medical profession cannot do it alone. You must influence other agencies and enlist their support.

16. Have you matured in life sufficiently to address your God on a daily basis? Call it prayer if you will. As a pastor, I encourage you to stay close to the Lord. "What's it all about?"

17. You may have heard the advice to take your work seriously, but not to take yourself too seriously. Do you still have a sense of humor and can enjoy the light moments of life?

18. Do you diversify your interests so as to keep a balanced mentality? Is medicine your only outlet?

19. Do you take care of your own health? Is the annual check-up a part of your own routine?

20. Are you open to consider these reflections?

I cannot think of a better summary for this subject of "compassion," especially for physicians, than the parable in Scripture of the man on the road to Jericho who fell among robbers. A Samaritan "treated his wounds," pouring in "oil and wine." Oil was a symbol of soothing the inners and wine of bringing some joy. Soothing and joy are the elements of healing!

I commend the Florida Medical Association members for their desire to emphasize ethics in the profession. Time is none too soon. It is a massive task but you must begin and systematically generate

support.

Please consider the following prayer as a part of your ministry of service:

O Father in heaven, we ask your blessing on physicians and their families.
Make them instruments of your peace.
Where there is hatred, let them sow love.
Where there is injury, may they offer pardon and where there is discord—union.
Wherever there is doubt, have them bring faith and where they find despair, may they offer hope.
Where there is darkness, may they bring light and in all sadness may they be a source of joy.
O Master, grant that they may not so much seek to be consoled as to console, to be understood as to understand, to be loved as to love.
For it is in giving that we receive, it is in pardoning that we are pardoned and it is in dying that we are born to eternal life.

Amen

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Medical ethics and the medical entrepreneur: are they compatible?

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If you visit San Francisco, or if you live there, you may go to Chinatown to dine at one of the city's excellent Chinese restaurants. If you do, your meal will end with a fortune cookie. That fortune cookie might, by chance, contain a quotation from the 17th century sage Chen Shih-kung: "When doctors visit the rich, they are conscientious; when they visit the poor, careless." The sage wrote those words when medicine was just beginning to be practiced by specialized physicians rather than by a family member. For many centuries before that time in China, medicine was frequently a family practice in the literal sense. One member of a family would learn the skills of medicine and then have the responsibility of caring for the relatives. When the practice of medicine for money began, this scholar was moved to make his critical remark. He went on to say, "This is the eternal peculiarity of those who practice medicine for financial gain and not as humane concern." Certainly this is thought provoking and serious—not, as I flippantly began, a mere fortune cookie text. In fact, it is the theme of this article on physicians as entrepreneurs.

The *Oxford English Dictionary* defines entrepreneur as one who organizes and manages musical events. The word appeared for the first time in English only in 1878 and the *Oxford English Dictionary* gives



no other definition. It does, however, give the etymology, which is obvious if you know a little French: an entrepreneur is one who undertakes. Ironically, that is fairly close to undertaker, and many an entrepreneur has buried himself or herself. But as we understand the term now, an entrepreneur is someone who undertakes the risks of a business venture in the hope of achieving some gain. Thus, Chen Shih-kung's physician who "practiced for the sake of gain" was an entrepreneur. Is it also necessary that he or she practice "not out of human concern"? That is the essence of the ethical issue in medical entrepreneurship.

I am sure that most readers, particularly physicians, are deeply convinced that medicine is for the sick. The purpose of developing skills in medicine and applying them to patient care is to benefit those who suffer from disability, pain and illness. That is, put quite simply, the purpose of medicine. The question, "What about the patient?, is recognized as the central question by all who are concerned about medicine as a practice for the sick. But it is not a question that we can answer easily as we stand on the verge of major reorganization and restructuring of the forms of delivering and financing care. Even if it is taken as a fundamental principle of ethical medicine that physicians must, as Hippocrates admonished, "be of benefit and do no harm," it is difficult to see what benefit and harm will be in a future the shape of

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which we do not know. We will have to watch the evidence as it develops. We will have to look at the effects on patient care of every sort of change in the delivery and the financing systems.

I cannot predict the future under systems of care that are primarily or at least partially inspired by entrepreneurial principles. But I can look to the past, suggest the way in which the past affects the present and, in the light of that, imagine what some of the possibilities for the future are—and some of the dangers.

Imagine that we are going to do an archeology of the ethics of medicine. The ethics of medicine in western culture is a tradition for which we have literary evidence going back to the third and fourth centuries before the Christian era. Imagine that that long tradition is like a modern edifice built on the foundations of many previous buildings, like some of the old churches of Europe. Imagine that we are excavating below the modern building, which represents current medical practice and its form. We can glimpse what lies beneath that structure. What are the earlier parts of this church, this pyramid, this temple that have been built up during the past 4,000 years in western culture? There are four levels that can be seen quite clearly in the successive foundations of that tradition we call medicine. The present structure stands on the top of all of these. None of them has ever been completely abandoned, though some of them are quite deeply buried. But all of them affect the present. They all affect the way in which we in western society and in the United States think about medicine: what it is, what it should be and how to deal with those people who come to practitioners for help.

The archeology starts at the bottom level, as if we were able to look down into this excavation and see the lowest structures that were built there centuries ago.

Greco-Roman medicine • The lowest structure we have any evidence about from history is the Greco-Roman practice of medicine. The great Hippocratic literature was written sometime in the third and fourth centuries before the Christian era. It consists of extensive treatises about the nature of diseases and of medical practice in the Greek world. Many physicians may have a dim memory of reciting the Hippocratic Oath at graduation. You probably recall little of its actual wording, but its spirit still prevails: I shall benefit my patient to the best of my ability and judgment. That phrase is indeed the core of the ethics of medicine. It says something very noble about medicine and imposes a rigorous obligation on those who practice it. But there is something very peculiar about it. If one looks beyond this short phrase to the rest of the vast literature of Greek and Roman medicine, one finds almost no expression of concern for the patient or of altruism.

Greek medicine was primarily a craft that had a product to be sold to make a living. Apart from some religious mysticism (which must, it seems, always be present to give medicine an aura of mystery), there was little more to it than that. Certain skills were taught by a master to an apprentice and those skills were peddled. The typical Greek physician was literally a peddler who traveled from town to town, set up a tent for a few days, gave a few lectures about diet and hygiene, passed out some herbal remedies, set some bones and then moved on. It was essential in that traveling doctoring to present a good image, make a nice impression and to please people. The best scholars of the Greek or Roman tradition tell us that the rare comments about benefiting the patient are actually advice about good advertising: when you arrive in town, do a nice job and please the villagers; next year when you come back, the folks will come back to you. You will have competitors dropping into that village, too. That is how your doctoring business will grow. The great philosopher Plato wrote, "The doctor should cultivate the art of healing, for even if the goal of medicine is healing and not making money, the self-interest of the craftsman is satisfied thereby."

Plato had it right: self-interest is one of the physician's goals. Apparently he did not consider this reprehensible. Certainly, making a living out of one's skills is a perfectly legitimate moral activity. Assuming that the other goal, healing, is also pursued, making money is consistent with being a physician. This is not the noble and altruistic view of medicine that we usually associate with the Hippocratic Oath, but it appears to have been the actual view of the Greeks at the beginning of our tradition of medicine. Self-interest, which is also a perfectly legitimate moral motive, was the ethic of Greek medicine. It lies at the bottom level of the tradition.

Religious level • If we move to the next level of the excavation, we find a fascinating development. I call the second level the religious level. In the third and fourth centuries after the Christian era, we begin to see a literature that speaks about medicine and healing as a religiously motivated activity. The sick were seen not as an encumbrance upon society but as those who should be pitied. Compassion was a virtue that the healer must cultivate. In the Jewish tradition, the work of human healing can be carried out only by permission of Jahweh, the all-powerful Healer; the physician is an instrument of the healing Jahweh. The physician must be worthy to be the instrument of God. In the Christian tradition, there are continual references to the story of the Good Samaritan; the stranger who find a wounded man by the roadside, binds his wounds, puts him in the care of someone who will watch after him and leaves money to assure that that care will be provided. The literature then insists that the good physician must demonstrate self-sacrifice to care for those in need.

In an eighth-century Latin text, the physician is admonished not to heal for the sake of gain nor to give more attention to the rich than to the poor, to the noble than to the commoner, "for the physician heals even as Christ heals."

An so we find at that second level of the excavation the introduction of a notion that was quite foreign to ancient medicine, that of altruism in the practice of medicine. Medicine is more than a trade, a skill that is sold at cost to the receiver; it must also be given at cost to the giver. The giver has the skill only by virtue of the favor of God who alone heals and thus must not use it solely as if it is his own. One of the monks of the Knights of the Hospital of St. John of Jerusalem, an order founded in the 10th century to care for sick pilgrims, comes across a wounded person whom he nurses back to health. When the grateful patient offers him a gold coin in thanks for his care, the monk says kindly but firmly, "Do you think I sell charity and the works of mercy?" He refuses the money. Of course, that sort of altruism is possible only when the healer is also a monk. Monks lived a communal life, so that they did not need income. Even then, after the laity took over the practice of medicine, as it did in the 10th and 11th centuries, we still see the insistence on the importance of altruism. But it takes on a bit of secular realism. For example, a 13th-century text instructs surgeons to charge their rich patients more so that they may give freely to the poor who need their services. Thus, the sliding scale appears for the first time in the 13th century. The self-interest of the first level and the altruism of the second can now be seen to coexist.

Professional level ● I call the third level in this excavation the professional level. Medicine begins to be thought of as a profession when it becomes a part of the life of the university. This happens in the 15th century, when medicine was accepted fully into the university curriculum. Not all physicians were trained in a university, but those who were trained there learned strict academic ways. The ideal of competence appears. The literature about medicine now begins to assert that the first duty of the physician is to achieve competence to master the science and the art. That becomes the ethical ideal of this third level. Because science and medicine become organized in this university fashion, they begin to do what universities always do: they give examinations, and the first examinations for licensure appear. A candidate had to show his masters that he had mastered a body of information and was able to apply it. The ethics of competence, starting in the 15th century, continues very strongly into modern medicine—and we should be glad of it. Now we have three levels in this ethical archeology—self-interest, altruism, competence.

The top level ● There is a fourth level at the very top, which begins primarily in the 19th century. This is a recent addition to the ancient, massive edifice of medicine, built during an era when the ideals of the American and French Revolutions were in the air. The ringing words "rights" and "equality" were heard in the culture. The protection of the public health became a recognized duty of governments. Slowly, the idea develops that individuals have some right to be cared for. The floor plan of that structure remains very much what it had been for centuries: medicine practiced by solo practitioners who charged those who could pay and provided charity care to a few who could not. But other rooms were being built: the system of public hospitals and clinics. The first national health insurance appeared in Bismarck's Germany, based less on a respect for rights than as a pragmatic means of maintaining a healthy labor force and decreasing the attraction of Socialism. In Great Britain, the National Health Service, born in the early years of the 20th century, became a universal system of care after World War II. In the United States, a vast health insurance system began to grow in the 1940s, primarily under the stimulus of the labor unions. Then, in law and in medical ethics emerged the concepts of the rights of persons in health care, the right to informed consent to care, the right even to refuse care if it does not meet one's values. These ideas and the structures to accommodate them have given a new shape to the ancient architecture of medicine. It is far more egalitarian than it ever was in the past.

The vast edifice of medicine is now in view. The lower, hidden levels are now exposed and it is clear that, in very complicated but powerful ways, all those lower levels support the visible building. Now what does this archeology lesson have to do with entrepreneurship? Allow me to draw some explicit conclusions—we might say "morals"—from the lesson. First, I want you to notice that the ethics of medicine does not exclude self-interest. It is a legitimate motive. It has always been present and has always been recognized as suitable. It has, as self-interest tends to do, caused trouble and required containment and limitations. The major tension for many physicians in their own personal life is the stress that they feel between self-interest and altruism. Still, self-interest is a legitimate and ethically appropriate motive.

The reason is obvious: not many physicians are monks. Physicians cannot, as did the monk-physicians of the Middle Ages, practice entirely for free. But when the concept of entrepreneurship is added to self-interest, an emphasis is added that traditionally has been seen negatively. There has been, for more than 2,000 years, a literature of criticism and satire about physicians; it is almost always directed towards the physicians as entrepreneur. Some of it is very amusing, but it is also heartbreaking.

Campaign against quackery ● In the 19th century in in the United States, a great campaign was waged

against quackery. It is a fascinating history about overt solicitating of patients, dramatic claims of cure very specific for diseases, the invention of Rube Goldberg therapeutic machines, even invitations to the public to come in and watch a famous surgeon operate. The physician was a huckster, some might say an entrepreneur. These activities brought medicine into serious disrepute. Organized medicine slowly realized this and mounted a campaign to identify quackery—not an easy task in those days of little science and much empiricism. Part of the campaign was necessarily directed to advertising, which had reached exaggerated and flamboyant levels. Physicians had to retire behind a simple shingle and a business card. One of the prominent tools of entrepreneurism was withdrawn from physicians. Notice that I have said, not that the entrepreneurial spirit is in itself wrong but that when an entrepreneurial spirit appears in medicine, it leads to distortions in the values on which the medical tradition was built. I do not consider entrepreneurship to be unethical but to pose certain dangers to the ethical practice of medicine.

Entrepreneurship, altruism and competence ● In conclusion, I will suggest what those dangers might entail at present. Needless to say, entrepreneurship means many things in modern parlance. Mere good business sense and efficient management are integral to it. Certainly, these are no threat to the ethics of medicine; indeed, they can improve ethical practice. The entreprenuerial spirit, however, does imply at least three things in all its incarnations.[1] First, it is generally considered ethical for those who are involved in risk-taking ventures to avoid an unprofitable market. A grocery chain finds that it has a store in a poverty area; the population cannot affort to buy their groceries. It is difficult to construct an argument that proves the company has an ethical obligation to continue to operate that store at a loss. So it is generally considered perfectly ethical to plan and to manage your risk, taking in ways that exclude the unprofitable market.

That element of ethical entrepreneurship poses a problem for the element of the traditional ethics of medicine that I described as altruism. Altruism, as we usually understand it, requires that risks are taken with no or little assurance of return. That is what altruism means and how it differs from enlightened self-interest. If it is true that the traditional ethics of medicine has been built on one foundation called altruism, then the principle of avoiding the unprofitable market seems to pose a serious, or at least a perplexing, problem.

Second, the ethics of risk-taking ventures permits the creation of markets for your own product. And, in the modern era, this has become a major enterprise through advertising. Markets are created by focusing on directing desires towards consumption. Again, this seems legitimate entrepreneurial ethics. Every honest advertiser and honest businessperson knows that there are limits and, yet, everyone allows the creation of "certain needs": stimulating persons' intersts in something so that they feel they need it even if they may not. For the most part, this is relatively harmless. Yet, we may sometimes become extremely critical of it, such as the practice of creating in children the appetite for cereals that have a high sugar content. For the most part, though, a creation of a market is perfectly legitimate.

This seems to raise problems for what I call the ethical tradition of competence. The main feature of competence is the ability to make the most effective response to the most precisely recognized need, and this is also good clinical competence. A competent physician thinks through a differential diagnosis by excluding all the things that do not need a response until the one that does is found, and then medical skills are directed precisely to that need. A physician does not create needs and, in fact, should abhor the creation of needs for service (although one of the most strident critics of medicine recently said this is exactly what physicians do!) Imagine some doctor rejoicing, "We are really lucky in this hospital, we've got a lot of nosocomial infection here. That means more business." So when you think about the entrepreneurial ethic that allows the creation of markets by the stimulation of consumption and contrast it with the traditional ethic of competence, you begin to see conflicts or at least perplexing problems developing. Will we be selling medicine that isn't needed?

Finally, the ethics of risky ventures permits the elimination of unprofitable products and services. If a business has a line of products or goods that simply does not sell, or a line that costs more to make than will be realized in return, there is no ethical problem about cutting it out. There may be some fuss over it — remember people shouting a few years ago when the convertible was eliminated. But it is hardly an ethical outrage to cease producing an unprofitable product.

This concept seems to have some implications for the top level of the ethics of traditional medicine, namely, the issues of justice and rights. It we ask what justice in health care requires, we find that the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research proposes "equitable access to adequate levels of care." This is admittedly a vague formulation, yet it is obvious that included in an adequate level of care are many services that are on the whole unprofitable. Many of the things done in primary care and in pediatrics are in themselves unprofitable and must be supported by some sort of subsidy or cross-subsidization. These sorts of services may be the first to go in an entrepreneurial system.

There are many reasons for the ways in which fee structures have been developed, but if an adequate

level of services is to be maintained, then the ethically permissible elimination of unprofitable services creates an interesting problem for the ethic of justice in health care.

Conclusion • In conclusion, I believe that there is no absolute contradiction between the entrepreneurial spirit and the spirit of traditional medical ethics. In fact, if the entrepreneurial spirit is seen fundamentally as the ethic of self-interest, it has a legitimate place. But I must add that the entrepreneurial spirit can encourage self-interest at the expense of altruism, competence and justice. One of the features of the entrepreneurial spirit in the United States is its enormous creativity. There are all sorts of ways to sell your product. Whenever one way turns out to be inefficient or to violate antitrust regulation, for instance, new ways are created very rapidly. All sorts of organizational structures, of forms of cooperation, of modes of financing and of mixtures between public and private sectors are available and open to us. In this conference you heard a great deal about those possible combinations. But as they are carried out and as all of these new ways are tried, it remains essential to ask how self-interest can be kept as merely one of the four levels that are part of ethical medicine.

That imaginary fortune-cookie message represented a situation in which self-interest had taken over from humane concern. That little fortune-cookie paper should be kept in your pockets to look at every once in a while as you bring to bear the enormously creative possibilities of American ingenuity on new forms of providing care.

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The pale blue eyes of Jeffy Glick

Albert Howard Carter III, Ph.D.

I was in the check-out line at the grocery store when I felt it, a strange pressure. I had not felt this for a while, but it grew slowly upon my consciousness until I realized it was the insistence of a gaze. From some quarter, eyes were probing me. I turned my head to find, yes, in the next line a small child in the seat of a shopping cart; he was staring at me with blue eyes. Young children who have not yet learned about eye aversion are harmless, so we often play their innocent game; we wave, smile, make a face. I was about to wave when the child's mother, finished with unloading the groceries, noticed the child's staring and rapped a tin can on the shopping cart. "It's not nice to stare," she scolded, loud enough for me to hear. Her purpose, I suppose, was to tell me that she was disciplining her child but perhaps also to warn me away from staring at the child (or, for that matter, at her).

I drove home a little more slowly than usual, trying to summon up the source of something, and I wasn't sure what, but the child's blue eyes seemed stolen from another head somewhere in the past. There was something still deeper than the check-out line incident, perhaps something I had buried in my memory. It was not until I pulled into the driveway, deserting my inquiry for my usual thought —don't drive over the cat, will someone help me with the groceries, what's on tv tonight—that the answer, unbidden, popped into my mind, as unbidden as those eyes in the supermarket: Jeffy Glick.



I didn't tell you that I'm a doctor; a geriatrician: I work with old people. During med. school I rotated through the various services; it was on my second rotation, pediatrics, that I met Jeffy Glick. My three-month rotation was divided into two parts. The first month I worked in the clinic which screened patients being admitted to the hospital. After all, you didn't want a kid to come in for a tonsillectomy and bring strep throat for all the other children. It was a good job for a med. student: you got some patient contact and didn't have much of a chance of screwing up anything important. So we did histories, physicals, wrote down "Rule out wrist fracture, strain, congenital mal-alignment," which meant "I think it might be one of these; you docs, who know better, check it out."

"This is Mrs. Glick and her son Jeffy," the nurse said one day, handing me a folder, nearly empty. It was my job to get the chart started right.

"How do you do," I said, shaking Mrs. Glick's hand, then squatting to shake Jeffy's hand. He was dressed in a brand new cowboy suit. He hung in his mother's skirts, not extending his hand, not looking

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at me.

"Well, let's see here," I tried, "a cowboy suit! And it looks brand new. What all do we have here: boots, and chaps, a red cowboy shirt; yes and a vest—looks like real leather." As I named each item, he slowly turned toward me. "A badge, and one, no, two pistols." He was all the way turned now, staring at me with bright blue eyes, perfect, sunny, little-boy eyes, big deep, trusting, like in advertisements. He pulled at his neckerchief around his neck until I said, "And a bandanna." Then he pointed to his mother's hand where, sure enough, his cowboy hat was cradled.

But it was those eyes that stole my heart. What a kid! For whatever reason he was there, we'd take care of him, and have him home, healed and growing into full childhood. Even as I squatted on the floor, touching him on his shoulder, I could see some swelling in his neck: we'd have to check those lymph nodes. He was scared of me, the hospital, the fact that he needed to be there at all, but we'd fix him up. I felt like a god swooping down to save him.

By the end of his history and physical, it was clear why Jeffy Glick was being admitted: for some kind of infection that his lymph glands were responding to. As I palpated the glands just below his jaw, I could feel rock-hard balls, like big marbles. Without his clothes, he had lymph glands bulging and hard in his armpits, his groin. "Don't let it be cancer," I said to myself. But it was: lymphadenopathy cause by a lymphoma, was the diagnosis, I later learned. Well, even at that, we'd lick it, I said to myself.

One month later, my job changed from the clinic to the wards, still in pediatrics. Oh good, I thought, now I can see how Jeffy Glick is coming along. He would have had about three weeks of treatment as an in-patient. Sure enough, I learned he was in Room 217-West, and I debated whether to drop in or to go by routinely as part of rounds. I had plenty to do and thought about it until the decision was made for me because of my waiting (and, I admit to myself now, I wasn't really sure how he'd be doing); so I ended up seeing him on the introductory rounds with the resident.

Yes, I figured, he'd be in a gown, and look small in the big bed, but I didn't think that he'd be bald, because of the chemotherapy. The neck masses were down, but so was all of his body fat, so that he was scrawny, even winzened. Those bright blue eyes stared out, some of their luster gone. As our group came into the room, it was the resident first, then two interns, then four med. students, myself pressing forward to see him. Maybe to greet him, to say that I remembered admitting him and so on. But as we looked at him, he looked back at me with eyes that seemed to accuse, to mock. I hung back, afraid to be close, almost afraid to let him see me.

There are advantages to teaching hospitals, but being practiced on by medical students is not one of them. As I put in I.V. lines for the first several times, I was awkward, even inept. It was always worse when I missed the first time, because then the patients became more tense, and so did I. The veteran nurses hated witnessing this work of beginners, and so did Jeffy Glick. As he was wheeled down to the treatment room, he knew what he was in for. As he looked at me, he knew I wasn't very good, and I knew that he knew. When I failed to hit one of his veins the first time—no easy matter with children's tiny vessels—his fear and anger grew, and so did my anxiety and, unfortunately, my clumsiness. This sad scene repeated over several days. Our relationship, at least in my eyes, deteriorated. His gaze now challenged me, inspected my work, plumbed my character; how badly are you going to hurt me this time?

Every day I saw Jeffy, and each day he grew weaker. He was my first dying patient, the first one to betray the faith I had in medicine, that formidable tool. In the right hands—namely mine—it should save! But Jeffy was a "non-responder," they said, a disastrous case. We did everything "right," and he got worse. His face was hollow, his demeanor slow. He didn't complain; he didn't react. He was silent, his pale blue eyes staring vaguely out of his hollow face. On rounds, I would stay near the door, eyes averted, as far from his bed as I could. When I stole a glance at him, his eyes would often already be on me, and I would read in them anger, betrayal, a silent bewilderment that accused me, mocked me, criticized me. He had power over me now, through the eyes of an old man, a wizard, a visitor from the world of the dead.

The chemotherapy ripped his system, wrecked his gut, giving him diarrhea, which irritated his skin to a nasty rash. I would glance at this macabre parody of a child who came in some seven weeks back, in his cowboy suit, and ask "Why?" I never got a good answer, of course, but I learned something about tragedy and the limits of medicine. In this sense, Jeffy Glick was one of my teachers—one of the best, if most painful. His pale eyes seemed on some days the "evil eyes of death" but I learned that such a designation was really a measure of my own fear, my own mortality clouding my vision. With that realization, I felt safer going to his bedside, touching him, and crouching, once again to meet his eyes. His eyes were an unearthly pale blue, like the arctic or heaven itself.

Just how long would this grotesque mixture of slow dying and futile treatment go on? The medicine that I wanted to rescue him was now his tormentor, prolonging his death beyond all common sense. Why did we persist in holding him prisoner in our logical, sterile world? Checking that the door was closed, I knelt by his bed.

"Hey cowboy," I whispered. The pale blue eyes opened slowly focused on me, at least I think they did. I raised my half-closed fist up the side of the bed and toward his face. A foot away from his nose I held my

fist tight a moment, then extended a rigid forefinger, aiming between his eyes. I cocked my thumb.

"Bang, bang, Jeffy Glick, you're dead," I said slowly, but in a strong voice. He was too far gone to reply. Or perhaps his reply was this: the next day he was gone, the bed empty, the room scrubbed down.

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Metaphors in medicine: A concept of physicianhood

Yvonne Cummings, M.D., F.A.C.P.

The scene of morning attending rounds is familiar to and understood by all who participate in the giving and receiving of health care. The attending physician tells the resident house officer to assemble the troops (students) for rounds. This platoon of physicians and students will visit all the patients on the service. In a typical morning as many as 20 patients will be seen during the two hour visit. As time is of the essence, orders and the discussion of differential diagnoses for each patient are given rapid-fire. The hierarchial nature of this group is evident at a glance. The attending physician leads the procession through the corridor and wears a suit or a long white coat. The resident, who today also wears a long white coat, carries a clipboard, wears a hospital identification badge, and is in constant motion. The students follow several paces behind, wear short coats, and try not to speak.

We hear the group speak of aggressive therapy for the patient with a compromised immune system. The resident is asked about his plan of attack for the patient with undiagnosed fever and weight loss. As the team leaves the intensive care unit, the resident states that we are gaining on the patient with sepsis and acute renal failure. During the discussion of this patient, the intern is reprimanded by the attending for her shotgun approach to ordering laboratory test. She remains silent and joins the students.



The patients, who are the other major participants in this scene, understand very well the nature of attending rounds. The patients know that this is their opportunity of the day to see the head doctor. They address all their questions and concerns to the attending. Not uncommonly, in this five-minute encounter, a patient will reveal important diagnostic information to the attending physician. The residents and students, who spent two hours with the patient the night before, are surprised and embarrassed at this exchange, for many times the new information contradicts what they have told the attending about the patient.

This morning ritual is repeated daily in hospitals across the country. The question that might be asked, and rightly so, is why write about something so common in our medical experience as morning rounds. I think that it is important at times to look at our rituals, for this behavior with its accompanying symbolism tells us much about who we are and what we believe. There is comfort in habitual activity; all are able to understand and execute assigned roles. Role theory states that social setting, in this case, a part of hospital medical practice, in large degree determines the individual's role performance and the way in which the individual and his behavior are perceived. Unfortunately, because of the very nature of ritualistic activity it is also easy for the participants to assume that the roles are unchangeable and that the activity must always be performed in the

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prescribed manner.

Military language ● Thus an examination of the setting of attending rounds may give us some insight into the nature of being a physician. I believe that the aspect of this social setting which deserves further attention is the language that is used in describing the setting, and that is used by the participants themselves. According to Lakoff and Johnson communication is based on the same conceptual system that we use in thinking and acting.[1] However, we are usually not aware of our conceptual system. Our day-to-day thinking and acting, as with attending rounds, is done more or less automatically. Therefore, an examination of our language is one way to obtain a better understanding of our conceptual system.[1] The language of medicine is powerful, dynamic and metaphorical. The vignette of attending rounds is clearly couched in military terminology.

The distinct military flavor of the language of medicine can be seen from examples of our daily conversations (Table 1). Moreover, even our titles reflect a military association (Table 2). Clearly the medical profession is not part of the military, so the language of our conceptual system must be viewed as metaphorical. The essence of a metaphor is the understanding and experiencing of one thing in terms of another.[1] Thus medicine is understood and experienced in terms of the military.

Table 1.—Common Medical Metaphors.

Advances in medicine
Aggressive therapy
Combat infection
Pursue the diagnosis
War on cancer
Invasive tumors
Plan of attack
Gaining ground
WBCs—first line of defense
The disease wore down his resistance
Medicine conquered smallpox
Lost the battle
The patient is sinking fast

I believe that there are at least three factors which led to the development of this particular metaphor for the medical profession. First, after World War II, there was unprecedented growth of medical technology. Secondly, many of the country's physicians at that time had advanced their skills serving as military physicians. These returning physicians had a profound effect on the conceptual system of the medical profession. Many of them became the organizers of modern American medicine and the teachers of the next generation of physicians. Lastly, the third factor was the movement of medical practice from the office and the patient's home to the hospital. This required an organizational structure which had not been needed when medicine was practiced in the office or in the patient's home. In view of these circumstances, it is understandable that the language of the military became the language of medicine.

Table 2.—Metaphorical Titles.

Chief-of-Staff	House Officer
Division Chief	Officer of the Day
Staff Physician	

Interestingly, not only did the medical profession adopt the military metaphor, but the nursing profession also embraced the metaphor of military service. Indeed, the nursing profession, until recently, may have been even more firmly entrenched in this tradition. For nursing, this tradition dates back to Florence Nightingale who served as superintendent of nurses in British military hospitals during the Crimean War in the 1850s. Regarded as the founder of modern nursing, Nightingale was a practitioner and proponent of strict military discipline.[2] Descriptions in military terminology of the ideal nurse was the standard for the profession for many years. Students nurses were told to expect a life of toil and discipline. Loyalty and respect for the chain-of-command were seen as high nursing ideals. Charlotte Perry, an early leader in the field, urged her fellow nurses to have proper respect for rank, with obedience and deference to the commanding officers.[2]

Since the 1960s, the nursing profession has been struggling to redefine its role in patient care. Although the majority of nurses agree that the military tradition of absolute loyalty and deference to physicians is not the role for the modern nurse, there is still symbolic representation in nursing of this older time. In some schools, stripes are still added to the nursing caps as students progress through the ranks, and the candlelight service is still a part of many nursing school graduations. Traditions die hard; the candlelight services stir memories of Florence Nightengale, the "Lady with the Lamp."

Physicians as fighter ● Accepting that a study of language is one way to better understand our conceptual system, and that in many aspect the language of medicine is metaphorical, I believe that an examination of the military metaphor will give some insight into the concept of physicianhood. Lakoff and Johnson have stated that the power of metaphors is due in part to their ability to focus attention on some aspect of reality while concealing others.[1] Thus, the military metaphor has helped to focus attention on the role of the physician as a fighter. The battle is against the universal enemies—disease and death. The explosive

growth of medical technology, armamentarium for the fighter physician, has supported this image. However, at the same time, the military metaphor has helped to conceal other important roles of the physician, namely those of teacher, mentor, counselor and comforter. Moreover, this image has focused attention on saving life as a goal of medicine. It has served to hide other important goals of medicine—education, prevention of disease, counseling, avoidance of harm, relief of pain and suffering.

During the last decade the medical profession appears to have experienced a loss of public confidence. Increasingly, we hear that the profession is viewed as impersonal, privileged and resistant to change. The professional prerogatives of physicians conferred by society are challenged daily. Truly, in terms of the military metaphor, the medical profession is under seige.

Many reasons have been given for the change in the public's image of the once sovereign medical profession. Rising health care costs, the malpractice crisis, the consumer rights movement, society's mobility and the aging population with the concomitant increase in chronic illness have all been suggested as explanations for the strained relations between patients and physicians. Although all of these factors have probably influenced the practice of medicine, I believe that the loss of public confidence in the medical profession occurred at a more fundamental level.

As medicine moved into the hospital with its technology, it assumed a new role. The profession now had the distinct possibility of curing disease; the profession had something substantial to offer patients. No longer was practicing medicine just the art of symptomatic treatment and comforting people as they died. Modern medicine had a profound effect on the way people experienced illness. The profession was thus held in high esteem and granted prerogatives not conferred on other segments of society. The image of the physician as a fighter had also captured the imagination of the public.

Unfortunately, scientific progress has been a double-edged sword for the medical profession. Not only is the technology expensive, but it also tends to reduce the amount of physician-patient contact. There is symbolic support of this phenomena in the vignette of attending rounds. As stated earlier, the symbolism in our rituals also give some understanding of what we believe and value. The traditional symbols of the physician, the white coat and stethescope, are still part of the medical scene. However, one traditional symbol, the black bag, has been replaced by a new symbol, the resident's clipboard. Medicine practiced out of a black bag tended to increase physician-patient contact. Whereas, I believe that the resident's clipboard is symbolic of the explosion in medical knowledge and technology which tends to decrease physician-patient contact. The resident uses the clipboard to organize his daily collection of data generated on each patient. The public interpreted this decrease in physician-patient contact as a sign of the profession's lack of empathy. Not only did patients want medicine's time-consuming technology, but they also wanted the doctor who knew them and saw them through life's passages. Thus came the public outcry that the medical profession is impersonal and is not concerned about the whole patient. I think that of all the accusations against the medical profession, it is the public's perception that the physicians are not concerned about their patient's welfare that bothers us most. I believe that the majority of physicians feel that they practice medicine in the best interest of their patients.

It may appear that I have introduced the military metaphor in order to examine the ills of the medical profession. On the contrary, I believe that the image of the physician as a fighter has been more positive than negative for the profession. All who have been patients, particularly if seriously ill, will readily acknowledge that they value the physician who will fight to do all that is possible on their behalf. Furthermore, I think that this image produced a sense of urgency and dedication that we may not have seen if modern medicine had grown up under another image. We are fortunate that the concepts of patients as clients and consumers were not introduced during medicine's infancy. Some of the critics who use these terms will quietly admit that client and consumer do not stir that sense of responsibility and dedication that is such a valuable part of the medical tradition. Even the cynics who attack the profession at its core when stating that medical technology has not increased life span have cheered with the rest of us the medical miracles that have relieved suffering. The story of smallpox immediately comes to mind.

However, there are problems of viewing the medical profession in terms of such a powerful metaphor. The notion of a fighter, at least for our culture, implies that the battle must be won. But the reality of medicine is that not all battles are won—all disease is not cured and death is inevitable. Disappointment, I believe, for both patients and physicians, is the logical conclusion when such noble ideals are attempted.

Adding to the difficulty of this view of medicine has been the rights movement which has paralleled the crisis in medicine. Two important aspects of this movement, the notion of entitlement and the distrust of authority, have left their mark on the medical profession. The public and the media now speak of both health and health care as rights. Distrust of authority, in part, has led to an unprecedented challenge of medical decision-making. Because of the nature of public expectations, enhanced by the rights movement, and the nature of medical practice, with less than perfect outcomes, it seems that the ground was set for strained relations between patients and physi-

cians. The result has been pronouncements that the medical profession lacks empathy, is arrogant and is more concerned with machine than people.

For physicians, the fall from grace has been difficult; disillusionment abounds in the profession. It is hard for a fighter to feel that he has done his best and still lose the battle. However, physicians continue to fight on behalf of their patients despite the adversarial nature of the relationship that has developed between the public and the medical profession. I believe that a look at the role of a soldier will help to explain some of the disillusionment seen today in the profession. A soldier's duty is to fight—to actively pursue the enemy. He has no time to reflect. In a similar way, physicians are asked to actively pursue illness—to use the modern technology. But at the same time, physicians are also asked to take time to reflect on the many issues that affect their patients' lives. This is an impossible task. The combination of an impossible task and the adversarial nature of medical practice has had an unfortunate effect on physicians. An unhealthy cynicism has invaded medical practice. It is seen in students and residents in their attitudes toward patients, and in practicing physicians in their comments about leaving the field. The profession is on a dangerous slippery slope of viewing disease as the enemy to viewing the patient as the enemy. It is not far down the slope to say that the patient remains ill because of noncompliance or that the patient is responsible for his illness. While these are valid concerns, medicine practiced from this negative point of view has detrimental effects on both the patient and the physician. The patient must remain defensive, and the physician misses the opportunity to help the patient understand his role in health and disease. In the process, the physician also misses an opportunity to learn more about the patient, and to advance other goals of medicine.

Crisis of identity ● Are there answers for this dilemma? I believe that much akin to the nursing profession, the medical profession is having a crisis of identity. We are asking the basic question of what is the future role of the physician and what are the future goals of the medical profession. Traditions die hard, but change is possible. We have seen the nursing profession change and accept the responsibility of a more mature role. Interestingly, the new role of the nursing profession also resulted in a metaphorical change. Nurse and the public view the profession as patients' advocates as opposed to loyal handmaidens of physicians.[2] It is time for the medical profession to also question the future of the military metaphor.

However, I believe that both the profession and the public must first accept the limitations of medical technology. It is unrealistic to expect that we can continue our attachment to technology without sacrificing patient contact. The role of physicians as fighters can no longer be the only image of medicine. We must reeducate ourselves as to the nature of the healing transaction.[3] Education is an essential component of all the goals of medicine listed earlier. It is helpful to remind ourselves that even our title, doctor, is derived from Latin *docere*, which means to teach. We must teach our patients, our students and residents, and ourselves.

Physicians have the opportunity to communicate with patients about the usefulness and the limitations of technology. The physician perspective can be exceedingly valuable to society, for we speak not only as medical experts, but also as sometime patients and knowledgeable citizens.[3]

William May has presented a most intriguing aspect of teaching for the profession, that is to enhance the impact that technology has had on the concept of disease. He states:

> **modern technology itself has allowed us in many respects to break with the understanding of disease that heretofore has minimized the teaching role of the healer. Traditionally interpreted, disease seemed to erupt episodically, breaking health and suspending the normal discretion that the patient exercises over his or her life. Upon falling ill, one surrenders one's natural authority until, through the mysterious interventions of the physician, a return to the normal world becomes possible. As the analogy would have it, disease disrupts health the way war interrupts peace. This irruptive and episodic account of disease, however, overlooks what Horacio Fabrega has called the processive character of both disease and health. Long before symptoms appear, the cardiovascular system may be preparing for catastrophe. A processive understanding of disease (which sophisticated monitoring devices make accessible to the modern practitioner) argues for a more collaborative interpretation of the physician-patient relationship. The physician must function as teacher, sharing information with the patient and engaging the layperson more actively to maintain good health.[4]**

One of our responsibilities is to educate the next generation of physicians. Realizing that students need to be confident in their ability to interact with patients, there have been admirable attempts to reinstate the humanities into medical education. Because of medical technology, patients are surviving extremely complex illnesses. Their need for human contact, for empathy and support, and for a clearer understanding of what they are experiencing is more acute than ever.[5] We have come full circle, with technology requiring that the art be restored to medical practice.

All medical schools are now mandated to include human values and medical ethics courses in their curricula. However, in many institutions only lip service is given to this aspect of the students' education. Severe time constraints force us to prioritize the curriculum. Medical ethics courses are viewed by students and faculty as "soft" subjects. Students routinely miss these classes in order to study for more "important" classes. Moreover, many schools do not offer ethics course work during the clinical years when

students are facing their first major challenges in patient care. For students to realize the importance of this aspect of medicine, faculty must relay in their attitudes the need for human values in medical education. Most medical students are young, healthy and have not experienced the degree of illness that they will face daily in their paticnts. This one factor alone makes it imperative that students are given the opportunity to study the humanities. Literature, philosophy and history expose us and connect us to our humanity.

Much of the previous discussion is applicable to our educational responsibility to residents. However, because of the nature of residency training, I believe that this aspect of medical education deserves a closer examination. The movement of medicine into the hospital and the embracement of the military metaphor has had its most profound effect on the way we train ourselves. Residency training is much akin to the soldier's basic training, but residents endure basic training for three to six years. In their role as recruits, residents who are able to maintain equanimity under the duress of 36-hour tours of duty are referred to as real troopers.

Much has been written about the pressures of residency training and their effect on the future lives of physicians. We are all aware of the intensity of training with its time pressures, sleep deprivation and assumption of major responsibility for difficult and emotionally charged problems. In an examination of thc reasons for the persistence of the intense commitments required of physicians, McCue has dispelled the notion that physicians must be trained in this manner.[6]

Our belief that such intense training is necessary to prepare for the difficult predicaments that physicians will have at all hours in medical practice is no longer valid. Practitioners very rarely encounter the crises that residents often face daily, and most practitioncrs have more time and resources to deal with them. Secondly, our fond memories of having survived such an experience with almost the fervor of a religious conversion can no longer be used to justify the status quo. We must look seriously at the loneliness, depressive reactions, disrupted marriages, drug abuse, cognitive impairment and suicidal thoughts and actions that occur in as many as one third of residents. Lastly, while accepting that learning and experience do increase as workload increases, there is a point where the demands for test ordering, consultation schcduling and paperwork offset the educational advantages.[6] Some hospitals still require residents to perform the clinical "scut work" of the past in addition to the clerical "scut work" of today. These duties crowd out time that should be spent learning clinical skills and the processive nature of disease and how it affects patients' lives.[6]

During eights years as an academic nephrologist, I had the opportunity to see disillusionment in colleagues and anxiety about the future in students and residents. I belive that our traditonal way of training and practicing cannot continue to sustain us. Having recently returned to residency training in psychiatry, I have one additional observation to support McCue's position that the structure of residency programs needs to be reviewed. The profession has generally accepted that the intensity of residency training was necessary for continuity of patient care. However, in many programs, residents now admit patients in a global sense. Thus, after night call, residents are not responsible for the care of patients that they admit.

I believe that it is time for the profession and society to reexamine the manner in which physicians are trained. We must give residents time to acquire broadbased knowledge, and also time to reflect on their own humanity, as well as that of their patients. Residents must know, along with the rest of society, that the use of technology as the only means of treating patients will never cure us. Residents need time to examine and reflect upon the many ethical issues generated by our technology. And finally, residents must be taught to care for themselves if they are able to care for their patients in an humane manner.

As a final thought, I believe that our most important challenge is the education of ourselves. We must willingly continue to share our knowledge with colleagues. The crisis in medicine has frightened us all, and has tended to produce a survivalist mentality of every man for himself. In terms of the military metaphor, the strategy from outside forces of divide and conquer has the potential to destroy the medical profession. In the words of William May, "war rules out long-term ties."[4] I believe that it is time for the medical profcssion to renew its ties with its healing tradition, with itself and with its patients.

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Withdrawing medical treatments: The difficult case of withdrawing nutrition

Ray Moseley, Ph.D., and James A. Jernigan, M.D.

By November 1984 Mrs. Helen Corbett had been in a vegetative state for two and a half years. Her life, such as it was, continued to be nutritionally sustained solely by a nasogastric tube. At this point it was apparent to Mrs. Corbett's husband, her attending physician, and two consulting neurologists that Mrs. Corbett's vegetative state was permanent and irreversible. Given this hopeless situation they all felt that the nasogastric tube should be removed and that Mrs. Corbett should be allowed to die.

However, several factors kept this decision from being immediately implemented. The first, and major, factor involved concern on the part of the physicians over possible liability ramifications.[1] This concern was enhanced if not caused by the fact that Florida has a law detailing certain procedures for withdrawing life-prolonging medical procedures.[2] One distinction that this statute embraces is between "comfort care," which may never be withdrawn, and "life-prolonging procedures," which may be withdrawn under certain circumstances. This law had been interpreted by the Florida Department of Health and Rehabilitative Services (HRS) as specifying the provision of nutrition and hydration as always being "comfort care."[3] This interpretation was believed by all parties involved in the decision to be a violation of Mrs. Corbett's legal and moral rights. Thus, guidance from the courts was sought before any final decision was implemented.



Dr. Moseley



Dr. Jernigan

In 1975 the Karen Ann Quinlan case helped the medical profession, the courts and the public to realize that with the widespread application of respirator technology comes the often difficult decisions of what is the appropriate use of this technology. Since that time there has been a growing consensus of judicial opinions, and among physicians and medical ethicists that patients, or their proxies, have a legal and ethical right to refuse or discontinue life-prolonging medical procedures.[4] However, until recently the medical procedures that are needed to provide nutrition to some patients have been largely exempt from the medical procedures that may be withdrawn. This seems to have been the case for two reasons, one based in common medical practice and the other largely symbolic.

First, the provision of adequate nutrition and hydration is a very high priority for the vast majority of patients since nutritional deficiencies depress the body's ability to fight disease. Thus, there is a great deal of emphasis placed on making sure patients eat

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well and regularly. For some patients the provision of sufficient nutrition requires a medical procedure such as the placement of intravenous, nasogastric or gastrostomy tube. These are invasive medical procedures, with associated medical risks. In other words intravenous, nasogastric and gastrostomy tubes are not benign. Intravenous tubes may cause serious infections and phlebitis. With the nasogastric tube there is the often significant discomfort of the tube as well as the danger of aspiration pneumonia. The gastrostomy tube requires a surgical procedure to both place and remove the tube, which carries risks.

These medical procedures like all cases of life-prolonging medical procedures may appropriately be withdrawn at the request of the patient under certain circumstances.[5] Two such circumstances are ethically clear. One situation is when there is no possibility of benefit to the patient.[6] This would be true of the patient who has permanently lost consciousness. Although the nasogastric tube would maintain the patient, it would not help the patient's condition. Another quite similar situation is when the medical procedure is simply futile or inefficacious.[7] An example might be a patient who has a near total body burn where survival is unprecedented.

In the first situation there seems to be no very strong ethical imperative to provide nutrition. It will not improve the patient's condition and there is no hope of improvement in the quality of life of the patient if nutrition is maintained. However, some patients may hold that purely biological, even if permanently unconscious, life is of some value. Because of this and out of respect for the right of the patient to make decisions, the treatment wishes of the patient should be followed. A decision to withdraw nutritional support should be made in these cases by the patient, preferably through an advance directive, or a patient's proxy. The case of Mrs. Corbett falls into this category.

Although Mrs. Corbett left no advance directive stating her treatment wishes, her proxy, Mr. Corbett, confirmed that Mrs. Corbett would not have wished to live in her condition and that she would have wanted her nasogastric tube removed. In this case Florida's Second District Court of Appeal in April 1986 upheld the decision to remove the nasogastric tube.[8] The Florida Supreme Court refused in July 1986 to hear the case, thus letting the Court of Appeal opinion stand.

Exempt procedures ● When nutritional support cannot be easily tolerated by the patient and the patient's death is imminent, e.g., within a few days, no matter what medical procedure is attempted, the physician has no legal or moral obligation to provide or offer medical procedures giving nutritional support, if the nutritional support would not serve to make the patient more comfortable. To do so would simply be a futile and inefficacious gesture. Also, such procedures in these circumstances may be contraindicated, based on the economic waste of medical resources and on the fact that in many cases patients who are allowed to die without receiving nutrition and hydration may die much more comfortably.[9]

A more ethically difficult category for physicians to accept are those patients for whom a medical procedure such as a nasogastric tube causes a disproportionate burden to the patient.[10] This situation calls for a weighing of nutritional support vs the risk and discomfort of the actual medical procedure and/or of continuing life under extremely painful condition. Since these sorts of decisions are based on an assessment of the burdens to the patient these decisions are best made by the competent patient. Thus, irregardless of a physician's assessment of need, a patient may find the discomfort of or life with a nasogastric tube is simply not worth enduring. When the patient is incompetent a proxy decisionmaker should make the decision whether to withdraw nutrition from the patient. This decision should be based in rank order, on a written advance directive, verbal instructions made when the patient was competent, the values of the patient, and finally because the burden of providing nutrition greatly overrides the benefit of the nutrition.[11] In this last situation such decisions might be appropriately made by a proxy of a patient who had severe dementia and who must be constantly restrained to prevent the patient from pulling out the nasogastric tube. The emphasis is on following whenever possible the desires of the patients expressed when they were compentent.

A second reason that medical procedures which provide nutrition have been usually exempt from procedures that may be withdrawn is that provision of nutrition conveys in medicine the essence of care and compassion. Conversely the withdrawal of nutrition carries with it the powerful symbolic message that one no longer cares about the patient. From this it is argued that physicians should as a general policy provide nutrition. The powerful image of a person painfully starving to death rightly causes strong emotional reaction. However, this general policy should not be construed as an absolute rule. The vast majority of patients near death do not crave nutrition. Further, it should be clearly understood that the symbolic "picture" of forcefully taking away a bowl of soup from a person differs significantly from the withdrawal of nutrition being provided by a nasogastric tube or gastrostomy tube. These sorts of nutritional support are invasive medical procedures. Withdrawing the medical equipment that provides nutrition is clearly distinct from abandonment of care. Comfort care, such as needed pain medications, should always be provided to keep the patient as comfortable as possible. This point must be made absolutely clear to family and especially to the nursing staff who provide the great bulk of care.

In Florida much of the debate over the withdrawal of nutrition and hydration centers not on whether it is ever ethical to withdraw these medical procedures but on whether it is legal to withdraw these procedures. The Corbett case helped clarify the patient's right to refuse medical treatments, including nutrition, by saying that any state law that restricted that right would be unconstitutional.[12] By so ruling the Corbett court interpreted the Florida Life Prolonging Procedure Act (LPP) as being applicable in the limited circumstances covered by the act. It said that just because other circumstances of withdrawal of treatment were not explicitly covered by the LPP, this did not mean that they were illegal. This ruling then recognizes that patients have a right to have a nasogastric tube removed.

One advantage of strictly following the LPP act is that it confers immunity for physicians who respect treatment withdrawal wished when the provisions of the act are followed.[13] Unfortunately, the Corbett court ruling does not grant the physician immunity from suit for respecting requests to withhold or withdraw nutrition. However, too much can easily be made from this. Suits against physicians who respect a patient's or proxy's wish to withdraw treatments including nutrition are extremely rare and have not been successful. At present there are amendments before the legislature that would modify the provision of the LPP act which wrongly restricts nutrition to being stipulated as always comfort care. This amendment would allow nutrition to be withdrawn under certain circumstances and would extend liability protection for physicians who respect a withdrawal of nutrition request.[14]

Unfortunately in the meantime this uncertain legal environment leaves some physicians unwilling to agree with legitimate requests to withdraw nutritional support. In addition, HRS regulations, which dictate practice policies in nursing homes, require that patients be discharged if nutrition is not desired by the patient, proxy or physician.[15] This presents serious legal and ethical conflict for those parties who wish to respect the wishes of a patient.

Terminal illness • One other problem that often causes concern from physicians and institutions who are asked to withdraw nutrition is the determination of whether the patient is terminally ill. The Florida LLP insists that the patient must be designated as terminally ill before a life-prolonging medical procedure may be withdrawn. "Terminal" is usually defined by physicians, when it is defined at all, as being when death is imminent. Strictly following this definition and the Florida LLP would allow only those patients to withdraw from life prolonging medical procedures whose condition would allow physicians to make the notoriously difficult prediction that a patient only had a few days to live. Thus, many other patients who have medical procedures which are inefficacious, offer no benefit or are extremely burdensome would continue to suffer despite any desires they might have to withdraw from these procedures. Patients such as Mrs. Corbett who are in a permanently vegetative state may exist in that condition for years. Indeed, Mrs. Corbett was in that condition for two and a half years!

The Court of Appeal in the Corbett opinion, as have other Florida courts, avoided this dilemma by merely stipulating that Mrs. Corbett was "terminally" ill without addressing this point.[16] This remedy however, offers little reassuring guidance to physicians and medical institutions. The confusion remains over exactly how to define a terminal condition.

The ethical reasoning behind the idea that the terminally ill may refuse unwanted procedures is that medical procedures which provide no "comfort," at that point only prolong the "dying process." Another way of saying this is that where a patient will shortly die no medical procedures whose use is intended to prolong life will benefit the patient. Being "terminally" ill, where death is imminent, is certainly one situation where patients should have the right to withdraw from or refuse medical procedures. However the rights of patients should not be limited to only this situation. It is by no means the only situation where the benefits of medical procedures are severely limited and where reasonable persons would reject life prolonging medical procedures such as in the case of patients who have permanently lost consciousness or whose medical treatments are overly burdensome. Irregardless of whether some courts would define these cases as "terminal," physicians generally do not label these patients as "terminal."

Some may argue that the use of the designation of being "terminal" is a line to prevent society from sliding down the slippery slope to the point where treatments are unjustly withdrawn. If this is the purpose the line is neither sharp, or ethically justified. We have argued that a better line is drawn which identifies those medical procedures which:

1. Are futile or inefficacious medical procedures;
2. Offer no possibility of benefit to the patient and
3. Produce a disproportionate burden on the patient.

Under the present situation physicians will continue to either refuse to honor requests for withdrawal, or they will seek what usually is untimely court guidance, or will honor requests for withdrawal of nutrition without liability protection. In this situation both patients and physicians suffer. The Florida Life Prolonging Procedure Act should be amended as follows:

1. Maintain that "comfort care" should not be withheld or withdrawn, but it should not specify any particular medical procedure as always being "comfort care;"
2. Discontinue the requirement that a patient

must be designated as "terminal" before a request for withdrawal of life prolonging procedures will be honored,

3. Give physicians immunity from civil and criminal liability for respecting a withholding or withdrawal of nutrition request from the patient or their proxy.

With a law that is clear on definition and one that allows physicians to respect patients legitimate treatment wishes, the present unfortunate state of pointlessly prolonging suffering and death through medical procedures will be replaced by a more compassionate, legal and ethical health care system.

Footnotes

1 Thomas E. Corbett v. The Honorable Joseph P. D'Alessandro, Second Court of Appeals, Case No. 85-1052, April 18, 1986.

2 Life Prolonging Procedure Act of Florida, Chapter 84-58.

3 Florida Department of Health and Rehabilitative Services Policy Letter #5-86, "Application of the Living Will Statute in Nursing," April 2, 1986.

4 When third parties such as minor children are involved or when adolescents are the ones making the decisions or when the patient is of questionable competence the patients right to make a decision to withdraw from a life prolonging procedure may be denied or may require additional confirmatory guidance from the courts or proxies.

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The Florida Medical Examiners Commission Ethical Advisory Committee

Wallace M. Graves Jr., M.D.

In October 1985, the Medical Examiners Commission of Florida was asked by then Governor Bob Graham to investigate allegations of impropriety from the study of brain tissue from electrocuted prisoners. All prison deaths including judicial electrocutions are required by Florida law to be autopsied; a medical examiner had, upon request but without consent from next of kin, supplied some brain tissue on six such cases to a university-affiliated neurophysiologist who hoped to demonstrate a correlation between abnormalities in the amygdala and criminal behavior.

The Commission heard statements from the parties concerned, and appointed an ad hoc Ethical Advisory Committee to make recommendations to the Commission on this and other matters of ethical concern. The appointed members of the Committee included an attorney specializing in administrative law, a public defender, the physician-director of a large medical school tissue bank, a bioethicist who serves a medical school as division chief for the Study of Human Values in Medicine, a Jesuit priest who heads a bioethics institute in a large urban hospital, and an orthodox rabbi who acts as ombudsman between the Jewish community and a busy urban medical examiner's office.

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The Committee met almost monthly from November 1985 to October 1986, assisted by staff members of the Commission. In addition to ethical guidelines for research within a medical examiner's office, the Committee members were asked to consider other potential problems of an ethical nature which directly impact upon the functions of such offices. Their deliberations included an historic and current review of societal benefits from autopsies and tissue retention, religious considerations pertaining to autopsies, concerns about informed consent, the needs and methods of educating the public about the value of autopsies, and the importance of the role of the medical examiners in organ donation.

The Committee's report affirmed the desirability and necessity of autopsies when authorized by Florida law for medical-legal purposes, stating ". . .the legislative determination that the public benefit derived from such autopsies is sufficiently important to eliminate any need for consent." The report hastened to add, however, that there is a need to ". . .apply the law faithfully and carefully, with maximum respect for the human sensitivities of all involved. The best ethical practice stresses the values of respect, compassion, kindness and courtesy beyond the minimum required by any policy or guideline."

With these two major considerations in mind, the Committee made several recommendations for ethical guidelines for medical examiners; they are para-

phrased below.

1. Medical examiners should perform autopsies expeditiously and thoroughly according to the law, provide pertinent information to the family and/or significant others, and promptly release the body as instructed by the family.

2. Medical examiners should be familiar with ethnic, cultural, religious and philosophical differences in their communities, so that such understanding can enable them to be sensitive to these differences and respect them as legitimate expressions of individual freedom. To this end, when there may be religious or personal objections to a complete autopsy, the medical examiner should exercise discretion in determining how much dissection, if any, of the cadaver there needs to be performed in order to fulfill the purpose of the law.

3. Medical examiners decide who may witness autopsies, recognizing, for example, the educational benefits to law enforcement and health care providers. Their decision is based on the societal benefit involved and the appropriateness of the circumstances.

4. Medical examiners must comply with proper requests for records under Florida's Public Record law, and may, but are not required to, discuss contents of the record during a telephone or personal interview or inquiry; good judgment must be exercised in such discussions. Under no circumstances should information which is not part of the public record be released or discussed with unauthorized persons.

5. Medical examiners should retain tissues and organs removed at autopsy needed for investigative, identification or diagnostic purposes. The medical examiner should be prepared to explain the purpose and the procedures involved to those who may not be aware of the reasons for such retention.

6. Medical examiners have a responsibility as "gate-keepers" of tissues and organs for transplantation or other therapeutic purposes. Medical examiners may retain and make available for such purposes tissues and organs when (a) the decedent has so authorized as evidenced by an organ donor card or similar directive, or (b) the legal next-of-kin has so authorized, or (c) the tissues are customarily removed in the course of an autopsy, no known objection from the legal next-of-kin is known, and, whenever practical, a reasonable effort has been made to notify the families to give them the opportunity to make known any objection.

7. Medical examiners may engage or assist in scientific research studies provided that (a) the research serves a useful purpose and follows good scientific principles, and (b) such research has been approved by a peer review panel or an institutional review board. Consent of the next-of-kin is required only if the material involved is not customarily removed and/or retained during the autopsy.

The Ethical Advisory Committee of the Medical Examiners Commission, the only one of its kind known, has been made a standing committee in anticipation of its valuable assistance in other ethical concerns or disputes which may arise during the performance of medical examiner duties.

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Ethics in medicine: The President's Special Committee on Ethics of the Board of Governors

Charles J. Kahn, M.D.

Ethics has been of prime concern to the profession of medicine almost since its inception. A number of new situations now require ethical determinations. I have not attempted to prioritize them nor, by order of their consideration, assign them any rank.

It becomes obvious that the care of the "indigent" requires a revised approach by the medical profession. To say that this is society's problem is begging the question. The bureaucratic approach to solution is failure. It is inadequate, inefficient, too expensive and unable, in itself, to provide quality medical care. But how do we, both as physicians and as organized medical bodies, approach the problem in order to provide a better solution?

In the past we volunteered service in charity clinics and on charity wards, for the most part in connection with training programs. Some still do, but not many. Can we solve the indigent health care problem by returning to an organized volunteer service program? Perhaps not, and it is fraught with the dangers of increased liability and loss of income. However, it seems we are obligated to try, not just to pay lip service to a program, but to organize and staff such programs and see that proper legislative protection is enacted. Because (trite but true) if we do not no one else can or will.

The Author
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Dr. Kahn is Chairman of the President's Special Committee on Ethics of Florida Medical Association's Board of Governors. He is in the private practice of internal medicine in Pensacola.



With the availability of new technologic modalities of diagnosis and treatment, new problems in the application of those modalities have arisen. How does one decide when their use should be limited or even prescribed? More and more we must consider the quality of life likely if the best result is obtained and the likelihood of such an outcome. Next we must add the degree of discomfort which the treatment imposes and, perhaps most important, the prestated desires of the patient and the family. The latter factor brings another dilemma into play. What does one do when the wishes of a patient or family are in conflict with one's own tenets? Does one accede or resist? No one can answer with certainty, but bending without breaking is certainly more humane than a wholly stiff-necked approach.

Organ transplantation is the most prominent example of another factor, that of economics or, euphemistically, cost effectiveness. Should this be even considered when, potentially, a life is at stake? Unfortunately, it must, and for that reason we must have ethics committees with a broad representation for no one can or should make such a decision alone.

Substance abuse and such disorders as Acquired Immune Deficiency Syndrome have presented new problems in doctor-patient relationships. Can we conscientiously withdraw our services because we disapprove of the lifestyle or fear (probably unreasonably) for our own safety? I think not. Ongoing caring is

the most important thing we can offer many of these patients.

There are programs which have been established for the support of the dying patient and his family. They are worthwhile and effective and yet physician participation in such programs appears to be minimal. Would not our patients be more secure if they knew we were participating? And would not the program volunteers and staff feel their service more complete if we were an integral part of it?

The Special Committee on Ethics in medicine will consider many problems such as these and attempt to provide guidelines for physicians and organized medicine. No solutions are possible from outside sources since the answers lie within each and all of us. We are privileged beyond any other profession and with the privilege comes obligations also over and above all others.

• Dr. Kahn, 14 West Jordan Street, Pensacola 32501.

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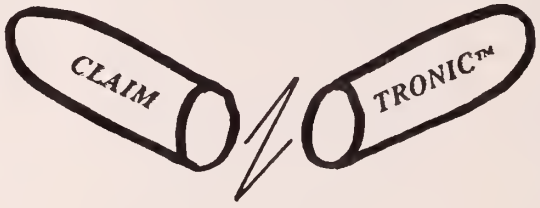
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NOTES & NEWS

Dr. Schiebler appointed to health policy board

Gerold L. Schiebler, M.D., a senior administrator at the University of Florida Health Science Center, has been appointed to a three-year term on a national health philanthropy board.

Dr. Schiebler, associate vice president for health affairs for external relations at UF, was named to the Health Policy Fellowship Board of the Robert Wood Johnson Foundation, an independent philanthropy that supports programs and projects to improve health care in the United States. The foundation, based in Princeton, N.J., has awarded more than $750 million in health-related grants since 1972.

The 12-member board selects participants for a fellowship program that provides one-year training opportunities in Washington, D.C., to mid-career professionals working in academic settings. The fellowship is designed to give participants a better understanding of major health policy issues and how they are addressed in the American political system.

Dr. Schiebler is the UF Health Science Center's primary liaison with the Florida Legislature and other governmental branches. A medical faculty member since 1960, he was chairman of the College of Medicine's Department of Pediatrics for 17 years through 1985. He is a member of the Florida Medical Association's Board of Governors and former editor of *The Journal*.

Organizing to negotiate

Currently there are 28 million health maintenance organization (HMO) enrollees in more than 650 HMOs nationwide, and membership continues to grow at an annual rate of 25%. An estimated 48% of office-based physicians now participate in at least one HMO or individual practice association (IPA). Likewise, preferred provider organizations (PPOs) have increased in number; there are now more than 550 PPOs either operational or under development.

This rapid growth of HMOs, IPAs, PPOs and other managed care systems has presented today's practicing physicians with a number of new challenges. How can physicians make sure that the managed care contracts they sign will allow them to remain patient advocates? How can they make sure that they will be in a position to influence the professional aspects of medical care while receiving fair compensation for their services? These are the questions addressed in the July 1987 issue of *The Internist: Health Policy in Practice*, the magazine of the American Society of Internal Medicine (ASIM).

Author Laura L. Allendorf, director of health systems and governmental policy at ASIM, notes that frustration with managed care systems and corporate medicine has led some private practitioners to look to unionization as a way of regaining the power and autonomy they have lost in recent years.

She writes, "A careful reading of the law governing such activity, however, indicates that unions comprised of fee-for-service physicians are of extremely limited utility... Short of securing an exemption from the antitrust laws, there are a number of ways in which physicians can legitimately organize to represent their interests. Properly structured from a legal standpoint, such organizations offer physicians the ability to influence collectively how health care is to be delivered in the community. These organizations include physician-controlled HMOs, independent practice organizations (IPOs), and preferred provider organizations."

An IPO is an association of physicians organized to provide a structure through which the investing physicians can enter into arrangements with HMOs and other forms of managed care systems and health benefit programs. Author William G. Kopit, a partner in the Washington, D.C., law firm of Epstein, Becker, Borsody and Green, believes that IPOs may be the answer for some physicians.

"IPOs have varied levels of complexity, from organizations that merely negotiate capitation rates for member physicians to organizations that also negotiate maximum fee schedules, create standards for utilization, conduct peer review and quality assurance activities, utilize primary care referrals and design benefit programs for employees," he writes. "Unlike an individual practice association, which is typically linked to a single HMO, an IPO is a freestanding organization which may deal with one or more HMOs, insurers or employers."

"Whether one is a fee-for-service physician with no ties to alternative delivery systems, or a participant in two or three such plans, it certainly can't hurt to be organized." That's the new philosophy of Don A. Wright, M.D., president of the Georgia Society of In-

ternal Medicine and a practicing physician in Savannah. When a large PPO was formed in Savannah that was to represent 25 to 30% of the workforce of that city, he knew area physicians would have to do something if they were to avoid being coerced into a less than appealing agreement with the plan. He decided that collective action was the answer, and with the help of negotiation experts, a number of physicians in the area formed a physicians' organization.

He writes, "When threatened, we learned rather rapidly how to overcome petty personality clashes and power struggles; after all, the socioeconomic consequences for our practices and our patients affected us equally. We have also learned how to replace the worried, anxious, ill-informed urge to 'sign-up' with careful, collective scrutiny and have obtained necessary expert advice at a reasonable cost to individuals."

C. Burns Roehrig, M.D., editor of *The Internist: Health Policy in Practice*, concludes, "Negotiation to achieve improvements in the system, and one's role within it, does not require a union. It does, however, require becoming well-informed and acquiring special communication skills."

Also in this issue, the sixth and final article in the series, *Making and Shaping Health Policy*, takes a look at how policy is made and promoted in ASIM. The monthly *InnerView* focuses on Jerry P. Clousson, a former labor lawyer who is now at the forefront in helping to establish physician organizations across the country.

For a copy of the July issue of *The Internist: Health Policy in Practice*, send $3 to ASIM, 1101 Vermont Avenue, N.W., Suite 500, Washington, D.C. 20005-3457. One year subscriptions are also available for $24 a year (10 issues).

New alcoholism, drug dependence standards examined in joint commission publication

New standards for substance abuse services are described in the latest publication from the Joint Commission on Accreditation of Hospitals. *Monitoring and Evaluation of Alcoholism and Other Drug Dependence Services* introduces and interprets the new standards. Suggestions are also provided to assist organizations design, implement, and perform monitoring and evaluation activities. The information applies to both freestanding and hospital-based drug-dependence programs.

"This publication provides valuable guidelines for the assessment, treatment, and continuity of care for substance abuse patients," said William F. Jessee, M.D., Joint Commission vice president for education. "The new standards also provide a framework for monitoring and evaluation of the quality and appropriateness of care, including specific elements of quality to be monitored."

The publication also offers quality of care monitoring and evaluation examples and discusses the nine-step procedure for these activities.

The publication sells for $30 and includes a glossary and resources for further information.

To order, call the Joint Commission's customer service unit at (312) 642-6061.

DEAN'S MESSAGE

A call to action

As a medical student and the son of a physician, I have until now silently observed what seems to be a three-ring circus deciding my future in the field of medicine. The three rings I speak of are, of course, the Medical profession, the Legal profession, and the Insurance companies. Unlike "The Greatest Show on Earth" until recently there was no ringmaster apparent to help moderate the confusion and focus the public's attention on the important points raised by each group. However, the Governor finally took action by appointing Marshall Criser (currently President of the University of Florida) to chair his committee on the malpractice crisis. Mr. Criser is well known to many as a voice of reason, moderation, and diplomacy which suit him well for the Herculean task of providing recommendations to help resolve this dilemma. I must applaud his appointment and the work that he has already done while at the same time I would like to convey my thoughts on the urgency of this matter.

The liability crisis in Florida has been a topic of much discussion and debate for more than ten years. During this time ten classes of medical students have graduated, and have been influenced by the issues and concerns being voiced. While these influences have undoubtedly improved care in some respects, they have also damaged it with regards to others. It is with this in mind that I write this article, to emphasize the need for urgent action on this problem.

Much has been written on the poisoning of the doctor-patient relationship due to the erosion of trust brought on by the crisis. Unfortunately, up to this point nobody has considered the effects of the liability issues on the doctors in training. What is to become of medicine in the future when a generation of doctors is practicing who have never known any difference? The callousness will eventually begin to show as more doctors are brought up in the malpractice

crisis era of medicine. Today's medical student is faced with a situation that is analogous to being a child in the early 50s and living in fear of the bomb. The difference being that in the 50s if you got hit by "the Big One" you died; in the 80s you live, but your career, professional reputation, and financial security are destroyed whether you win, lose or settle. Thus is is with tremendous concern for the future of patient care that I anxiously await legislative action on this problem.

John R. Robinson Jr.
President, Senior Medical Class
University of South Florida
College of Medicine

ENCORES!

An eight-count indictment of America's health care industry

The health care industry is guilty of eight major breaches of good public policy. By ignoring these serious faults, we are wasting lives and resources that America desperately needs for other public policy endeavors.

I bring an eight-count indictment:

● America spends more per capita for health care than any other nation, yet our health statistics are among the worst of the industrialized nations.

Health care costs in America total $2,000 per capita. By contrast, per capita health care costs are $500 in Great Britain and $200 in Singapore, yet the three places have approximately the same death and disease rates.

It's a national disgrace that we spend more than $1 billion a day on health care and yet there are 37 million people without full health care coverage. Other nations provide coverage for all their citizens at a fraction of our cost, and they have approximately the same results.

● Little or no thought is given to maximizing what our health care dollars purchase.

We never seem to ask how we can get the most health care for our money. We spend billions on technologically advanced medicine while ignoring many procedures that could increase health. While millions of Americans don't have access to basic health care, we're transplanting hearts into ex-smokers, spending billions on life-support systems and allowing 30% to 40% of the nation's hospital beds to remain open but empty.

America specializes in "glory" medicine, but we forget the basic health measures that could save far more lives. More people would be saved if we focused efforts on preventing disease instead of just treating it. However, the system allocates money to the glory medicine that brings publicity from the media.

● Unacceptable and wide descrepancies exist in medical practice in various regions of the country.

The list of variations is long and, to a large extent, unjustified. In many instances, differences in the rates of operations correlate only to the number of physicians in a community.

For example, women in Tampa or Orlando and Atlanta are 50% more likely to have hysterectomies than women in Chicago or Washington. Males in Los Angeles, Atlanta or Fort Worth, Texas, have a 60% greater chance of having an operation to remove part or all of their prostate glands than males in Detroit or Columbus, Ohio.

Hospital use is 60% higher in the Midwest than in the West. Computed tomography scans are performed seven times more often in certain parts of the country than in others.

● The health care industry wrongly leads us to believe that it represents the only way—or at least the best way—to good health.

The great improvements in health haven't come from doctors of hospitals. They've been accomplished through vaccinations, refrigeration, sanitation and antibiotics.

America could be healthier if we concentrated efforts on cutting the use of tobacco and alcohol, on improving our diets and using seat belts instead of doubling the money spent on health care.

We need to reconsider the way we allocate resources. For example, locking up drunken drivers would save more lives than hospitals ever will. A $1-a-pack tax on cigarettes would be more effective than another $100 billion poured into the health care industry. A national seat belt law would save more lives than all the CAT scans in America.

● We aren't wise enough to turn off the life-sustaining machines we were smart enough to invent. Hospitals routinely are reviving terminally ill patients, at great expense to the nation's taxpayers, just so they can die the next day.

Life-sustaining machines only delay death, and their use often causes families to think of the health care system as an enemy, not a friend.

● Defensive medicine is costing in America an estimated $15 billion to $30 billion a year. The legal system in America compounds the problem.

Almost every patient undergoes too many tests and X-rays because of the fear of lawsuits. The reform of the health care system won't occur until we dramatically reduce the threat posed by lawyers and lawsuits.

We should reject the sanctimonious, self-serving claims of lawyers who say they are the "protectors of patients' rights."

• The health care system suggests it can "cure" death, and it often acts and spends money as if it can. Thus, the system misallocates billions of dollars badly needed elsewhere.

Students in American medical schools are taught to consider death an enemy in all instances instead of recognizing that we all must die sometime. We euphemistically talk about the "right to die" as if we had the right to refuse, which we obviously don't.

The enemy of the health care system ought to be disease, discomfort, pain, suffering and poor health. Some 30% of Medicare expenditures are spent in the last few months of beneficiaries' lives, providing little or no benefit for the dying patient. Such spending only prolongs suffering.

Giving heroic and expensive treatment to each dying patient steals resources that our children need to re-tool America and build a better life for themselves.

• Health care has become an economic cancer that is preventing our goods from competing in the international marketplace.

American goods sold abroad are expensive because they contain a health care cost component that's three or four times greater than those of our competitors.

America cannot afford an expensive, inefficient health care system sitting atop a shattered economy.

The bottom line is that our health care system is costing us too much and producing too little.

I don't mean to indict all the dedicate and hard-working people who work in health care. After all, a member of my family had a serious illness and was saved through the efforts of physicians and a hospital.

However, I'm critical of a system that is costing America far too much for what we receive.

Richard Lamm
Former Governor of Colorado
Montgomery Fellow
at Dartmouth College

Reprinted from *Modern Healthcare*, July 3, 1987.

113th ANNUAL MEETING

Scientific Program

The 113th Annual Meeting scientific program has been completed under the leadership of Pierre J. Bouis Jr., M.D., Chairman of the Council on Scientific Activities and Committee on Medical Education Chairman, Orris O. Rollie, M.D. Program highlights are listed below and as in the past, up to 15 hours of AMA Category I credit will be available to program registrants.

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy and Immunology Society)
Saturday, September 19, 1987—8:00 a.m. to 12:00 noon
Mark Stein, M.D., North Palm Beach
Program Chairman

Introduction—Michael Diamond, M.D., President, Daytona Beach
"Sinusitis, Nasal Polyps and Asthma"—Sheldon Spector, M.D., Clinical Professor of Medicine, UCLA, Los Angeles, California
"Environmental Control—What is Known to be Useful"— Harold S. Nelson, M.D., Clinical Professor of Medicine, University of Colorado School of Medicine
"Dust Mites of Tampa"—Enrique Fernandez-Caldas, Ph.D., Assistant Professor of Medicine, University of South Florida, Tampa
Asthma and Allergy Foundation of America, Florida Chapter Break
"Treatment of Status Asthmaticus 1987"—Harold S. Nelson, M.D.
"Asthma—When All Else Fails"—Sheldon Spector, M.D.
"Ventilator Support"—Michael Diamond, M.D.
Panel Discussion
Luncheon and Business Meeting

SECTION ON ANESTHESIOLOGY

(Co-sponsored by Florida Society of Anesthesiologist, Inc.)
Friday, September 18 — 2:00 p.m. to 5:00 p.m.
Lawrence Berman, M.D., Gainesville
Program Chairman

"Perspectives in Risk Management in Anesthesiology"—Robert C. Covington, Vice President and Manager, Southeast Care Division, Alexander and Alexander, Atlanta, Georgia
Questions and Answers
Board of Directors Meeting
General Business Meeting

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Thoracic Society and Florida Chapter, American College of Chest Physicians)
Thursday, September 17—1:30 p.m. to 4:30 p.m.
Mark Snider, M.D., South Miami
David Solomon, M.D., Tampa
Martin Cohn, M.D., Miami
Program Co-Chairmen

Critical Care Medicine, Ethical Decisions and Risk Management Center—Martin A. Cohn, M.D., Moderator

Panelists: Rabbi Solomon Schiff, Director of Greater Miami Jewish Federation's Community Chaplaincy Service and Executive Vice President of the Rabbinical Association of Greater Miami, Miami. Reverend Dr. James J. McCartney, O.S.A., Director of Bioethics Institute at St. Francis Hospital and System Ethicist for the Allegany Health System, Miami. Jane E. Hendricks, Attorney, Specializing in Health Law, Executive Council of the Bioethics Institute at St. Francis Hospital, Miami. Alan Goldfarb, Esquire, Goldfarb and Gold, P.A., Miami. Charles L. Sprung, M.D., University of Miami School of Medicine, Miami.

"Determination of Death—Turning Off the Ventilator"
"Do Patients with Certain Diseases Abrogate the Right of Self-determination?"
"The Living Will—Must It Always Be Honored?"
"Obtaining Informed Consent"
"Malpractice and the Expert Medical Witness"

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)
Friday, September 18—1:30 p.m. to 5:30 p.m.
Saturday, September 19—8:30 a.m. to 12:00 Noon
Stephen Horwitz, M.D., Jacksonville
Program Chairman

"Cutaneous Signs of AIDS—Update '87"—Neal Penneys, M.D., Professor and Acting Chairman, Department of Dermatology and Cutaneous Surgery, University of Miami, Miami
Clinical Dermatopathology Conference—Richard J. Feinstein, M.D., Clinical Associate Professor, Department of Dermatology and Cutaneous Surgery, University of Miami, Miami
"Topical Psoralen Therapy of Alopecia Totalis"—Arthur Weissman, M.D., Associate Attending, Department of Dermatology, Mount Sinai Medical Center, Miami Beach

"Oral Hairy Leukoplakia II—Response to Anti-Viral Therapy" Jay Herbst, M.D., Resident, Dermatology, Mount Sinai Medical Center, Miami Beach
"Human Humoral Responses to Mosquito Bites"—Craig Leonardi, M.D., Resident, Dermatology and Cutaneous Surgery, University of Miami, Miami
"Human Adjuvant Disease"—Stephen J. Brozena, M.D., Chief Resident, Dermatology, University of South Florida, Tampa
Break
"Nail Cosmetics"—Richard Scher, M.D., Professor of Medicine, Brown University, Providence, Rhode Island
"Vasculitis and Endothelial Cells: New Concepts"—Thomas J. Lawley, M.D., Senior Investigator, Dermatology Branch, National Cancer Institute, NIH, Bethesda, Maryland

SECTION ON DIABETES

(Co-sponsored by American Diabetes Association, Florida Affiliate)
Friday, September 18—2:00 p.m. to 5:00 p.m.
Anthony Morrison, M.D., Tampa
Program Chairman

"Causes of Diabetes"—Anthony Morrison, M.D., Associate Professor, USF College of Medicine, Tampa
"Impotence and Diabetes"—Frederick Murray, M.D., Associate Professor of Medicine, University of Florida College of Medicine, Gainesville
Break
"Lipid Abnormalities in Diabetes"—Ronald Goldberg, M.D., Associate Professor of Medicine, University of Miami School of Medicine, Miami

SECTION ON FAMILY MEDICINE

(Co-sponsored by Florida Academy of Family Physicians and Pfizer Pharmaceuticals)
Friday, September 18—1:30 p.m. to 5:30 p.m.
Robert L. Dawson, M.D., St. Petersburg
Program Chairman

"New Concepts in Coronary Vascular Disease"—James F. Spann, M.D., Medical College of South Carolina, Charleston, South Carolina
"Lipids"—Mark Houston, M.D., Assistant Professor, Department of Internal Medicine and Co-Director, Medical Intensive Care Unit, Vanderbilt Medical Center, Nashville, Tennessee
"Management of Prostatic Disease: Guidelines for Primary Care Physicians"—Robert Rhamy, M.D., Veterans Administration Hospital, Miami
"Sports Medicine"—R. Stephen Lucie, M.D., North Florida Orthopaedic Center, Jacksonville

SECTION ON GASTROENTEROLOGY

(Co-sponsored by Florida Gastroenterologic Society)
Friday, September 18—2:00 p.m. to 5:00 p.m.
Patrick G. Brady, M.D., Tampa
Program Chairman

Introduction and Announcements—Patrick G. Brady, M.D., President
"Advances in Peptic Ulcer Disease Therapy"—Patrick G. Brady, M.D., Professor of Medicine, University of South Florida College of Medicine, Tampa
"Colon Carcinoma: Diagnosis, Therapy and Prevention"—Steve Goldschmid, M.D., Assistant Professor of Medicine, University of South Florida College of Medicine, Tampa
"The A, B, C and D's of Viral Hepatitis"—Allan Leibowitz, M.D., Associate Professor of Medicine, University of South Florida College of Medicine, Tampa
Break
"Medical Therapy of Gallstones"—Patrick G. Brady, M.D.
"Micronutrient Deficiencies and Assessment of Nutritional State"—Steve Goldschmid, M.D.
Panel Discussion

SECTION ON INTERNAL MEDICINE

(Co-sponsored by Florida Society of Internal Medicine and American College of Physicians)
Saturday, September 19—9:00 a.m. to 12:00 Noon
Wilbert Dawkins Sr., M.D., Jacksonville
Program Chairman

"Computerization of the Physician's Office"—Steven M. Zimmet, M.D., Chairman, Computer Services Committee, American Society of Internal Medicine; Mrs. Wendy Lewis, Independent Computer Consultant, Lakeland
Questions and Answers
Break
"Electronic Claims Processing"—Mr. Don MacCullum, Society Relations Manager, Medical Payment System (AMA), West Lake, Ohio; Mr. Churck Broes, District Manager, Wellcorp, Sparks, Nevada; Mr. Daniel G. Whitehead, Vice President, Marketing Provider Automated Services, Inc., Blue Cross/Blue Shield of Florida, Jacksonville

SECTION ON NEONATAL PERINATOLOGY

(Co-sponsored by Florida Society of Neonatal Perinatologists)
Thursday, September 17—1:00 p.m. to 3:00 p.m.
Jon W. Nagel, M.D., Pensacola
Program Chairman

"Current Status of Developmental Evaluation—Intervention Program for High Risk Infant and Preschool Children in the State of Florida"—Michael Resnick, M.D.
"Delivery Room Management of the Newborn—Recommendations Based Upon the Recent Changes in Pediatric Advanced Life Support (PALS) Guidelines"—David J. Burchfield, M.D.

SECTION ON NEUROSURGERY

(Co-sponsored by Florida Neurosurgical Society)
Saturday, September 19—7:30 a.m. to 12:00 Noon
Raul V. Rivet, M.D., Miami
Program Chairman

"Correlations of MRI with Other Diagnostic Testing in Spinal Disorders"—Judy Post, M.D.
"Evoked Potentials Monitoring During Neurosurgery"—Oscar Papazian, M.D.
Break
"Intraoperative Neurosonography"—Berta Montalvo, M.D.
Business Meeting

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)
Saturday, September 19—8:00 a.m. to 11:30 a.m.
Paul Gluck, M.D., Miami
Program Chairman

Resident Research Papers
"Anatomy of Pelvic Supports"—A. Cullen Richardson, M.D., Atlanta, Georgia
Break
"The Use of Hypnosis to Improve OB/GYN Care"—Larry Goldman, M.D., Vice President, Florida Society of Clinical Hypnosis, Ft. Myers
"An Anatomic Approach to the Surgical Treatment of Cystourethrocele"—A. Cullen Richardson, M.D.
Business Meeting

SECTION ON OCCUPATIONAL MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine, Florida Occupational Medical Association and Florida Chapter, American College of Emergency Physicians)
Thursday, September 17—1:00 p.m. to 4:00 p.m.
Nathan Grossman, M.D., Ocala
Program Chairman

Introduction—Nathan Grossman, M.D., Director, Marion County Public Health Unit, Ocala
"Preventive Aspects of Occupational Medicine"—Allen Koplin, M.D., Director, Hendry—Glades County Public Health Units. Former Director, Employee Health Service, New York City Department of Health
"Workers' Compensation Overview I"—Mr. Pat Wilson Parmer, Acting Director, Office of Medical Services, Florida Department of Labor, Division of Workers' Compensation
Break
"Workers' Compensation Overview II"—Ms. Nancy Rice, Consultant, Office of Medical Services, Florida Department of Labor, Division of Workers' Compensation
"Back Pain"—Brian Ellis, M.D., Chairman, Education Committee, Florida Chapter of the American College of Emergency Physicians, Melbourne
Presentation of the Joseph E. Baird Florida Occupational Medicine Association Award—Winning Medical Student Paper "Occupational Disease in the Commercial Printing Industry"—Raymond Lucas

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGEONS

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgeons)
Saturday, September 19—7:30 a.m. to 12:00 Noon
Mutaz B. Habal, M.D., Tampa
Program Chairman

"Communications Skills"—Arch Lustberg
Business Meeting and Luncheon

SECTION BY AMERICAN COLLEGE OF PHYSICIANS

(Co-sponsored by American College of Physicians)
Wednesday, September 16—1:00 p.m. to 5:00 p.m.
Panagiota Caralis, M.D., Miami
Program Chairman

"Cardiac Transplantation"—E. DeMarchena, M.D.
"Deep Vein Thrombophlebitis and Pulmonary Embolus: Approaches to Diagnosis and Therapy"—M. Gelbard, M.D.
"Evaluation of Lower Gastrointestinal Bleeding"—H. Manten, M.D.
"Management of Hypertensive Urgency and Crisis"—M. O'Connell, M.D.

SECTION ON CLINICAL ONCOLOGY

(Co-sponsored by Florida Society of Clinical Oncology and American Cancer Society, Florida Division, Inc.)
Saturday, September 19—9:30 a.m. to 12:00 Noon
Michael Harwin, M.D., Tampa
Program Chairman

"Treatable Poorly Differentciated Carcinomas of Unknown Primary Site"—John Hainsworth, M.D., Vanderbilt University, Nashville, Tennessee
"Carcinoid Tumors and Adrenal Tumors"—Robert Leeper, M.D., Memorial Cancer Center, New York
Break
"Childhood All-State of the Art"—Stuart R. Toledano, M.D., University of Miami School of Medicine, Miami
Question and Answer Panel
Business Meeting

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)
Saturday, September 19—9:00 a.m. to 12:00 Noon
Bascom Palmer Eye Institute
Harry W. Flynn Jr., M.D., West Palm Beach
Program Chairman

"Diabetic Macular Edema"—Harry W. Flynn Jr., M.D.
Discussion
"Techniques in Retinal Detachment Surgery"—David Kasner, M.D.
Discussion
"Strabismus Surgery"—Robert Lingua, M.D.
Discussion
"Common Eyelid Problems"—David Tse, M.D.
Discussion



Depressed and anxious, she's sitting out life instead of living it

From "looking"...







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to "living"...



FOR FAST RELIEF OF MODERATE DEPRESSION AND ANXIETY

See the difference in the first week[1]

Limbitrol®
Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) IV

Limbitrol® DS
Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) IV

PROTECT YOUR DECISION. WRITE "DO NOT SUBSTITUTE."

Please see summary of product information on adjacent page.

FROM LOOKING...TO LIVING...

to smiling again!

The rewards of Limbitrol

In moderate depression and anxiety:

- Rapid results—62% of total four-week improvement within a week versus 44% with amitriptyline[1]
- Earlier relief of associated somatic complaints[2]
- Fewer dropouts due to side effects—only ⅓ the rate of those patients taking amitriptyline, although the incidence of side effects is comparable[1]
- Fast improvement with less amitriptyline—⅓ to ½ the dose of patients taking amitriptyline alone[3]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.



SEE THE DIFFERENCE IN THE FIRST WEEK[1]

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

PROTECT YOUR DECISION. WRITE "DO NOT SUBSTITUTE."

References: 1. Feighner JP, et al: Psychopharmacology 61:217-225, Mar 22, 1979. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Dixon R, Cohen J: J Clin Psychopharmacol 3 107-109, Apr 1983.

Limbitrol® (IV)
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestations and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

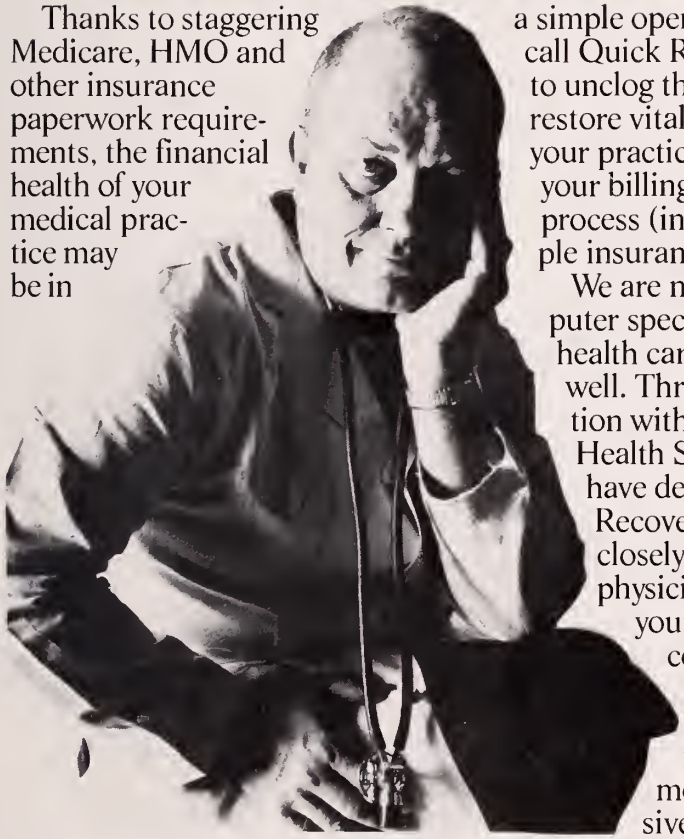
How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500; Tel-E-Dose* packages of 100, Prescription Paks of 50.

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BOOK REVIEW

Book Review Editor—F. Norman Vickers, M.D.

Abortion, Medicine and the Law

by J. Douglas Butler and David F. Walbert, 3rd edition, 795 pages, price: $40.00. Facts on File Publications, New York, New York.

The abortion issue ... in the beginning there was Roe v. Wade (1973), presently there is controversy and where it will end is still being discussed, debated and deliberated. This book is really a treatise on abortion. It is divided into four sections: law, medicine, ethics and an appendix describing the Supreme Court decision of 1973, the Human Life Bill (with testimony before the United States Senate) and an amendment to the Constitution on abortion.

Even though considerations of the abortion issue can be traced back to the 1920s, this book begins its review of the abortion issue by starting with the historic Texas court decision of Roe v. Wade in 1973 and taking the reader through the tumultuous ten years that followed. While the book is heavily weighted toward the legal aspects of the abortion issue (this does make for interesting reading), physicians may be specifically interested in the section on medicine as it covers such topics as wrongful birth, wrongful life, the psychiatric implications of abortion, demographic and public health experience, selective abortion, prenatal considerations and abortion practices.

The list of individuals contributing to the book is impressive and exemplifies the editors' attempt at impartiality on the subject. All interests involved in the abortion issue are represented. Many chapters are written by noted obstetricians, geneticists, attorneys and educators. There are chapters by bioethicists, a U.S. Senator and even a chapter by President Ronald Reagan.

Two individuals edited this comprehensive work: one is a physician and attorney and the other is an attorney. For anyone who seeks complete information on the history and background of the abortion movement in this country, this book is certainly recommended reading.

Pierre J. Bouis Jr., M.D.
Tampa

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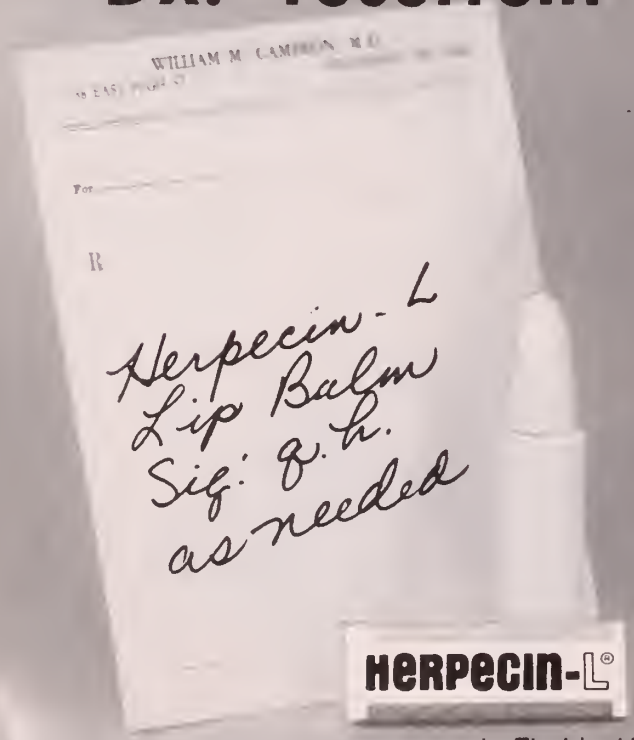
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In Florida, HERPECIN-L is available at all *Albertson's, Eckerd, Rite Aid & Walgreen* Drug Stores and other fine pharmacies.

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L42

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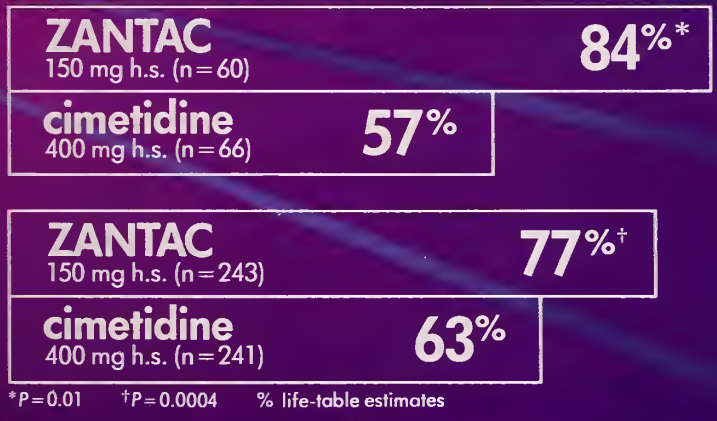
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Well-controlled clinical trials confirm: ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

FREE FUTURE

Percent of patients ulcer-free after 1 year of therapy



*P=0.01 †P=0.0004 % life-table estimates

All patients were permitted prn antacids for relief of pain.
Adapted from Silvis[1] and Gough[2]

These two triols[1,2] used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comporison af ather dosing regimens has nat been studied.
The studied dasing regimens are not equivalent with respect to the degree and duration af acid suppression ar suppression of nocturnal acid.
The superiority af ranitidine aver cimetidine in these triols indicotes that the dasing regimen currently recommended for cimetidine is less likely ta be as successful in maintenance therapy.

Zantac® 150 h.s.

ranitidine HCl/Glaxo 150 mg tablets

Glaxo / ROCHE®

See next page far references and Brief Summary of Product Information.

ZAN375 July 1987

References: 1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Karman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochlaride)

BRIEF SUMMARY OF PRODUCT INFORMATION

The fallawing is a brief summary anly. Before prescribing, see complete prescribing infarmatian in ZANTAC® product labeling.

INDICATIONS AND USAGE: ZANTAC® is indicated in:
1. Short-term treatment af **active duadenal ulcer.** Mast patients heal within faur weeks.
2. **Maintenance therapy** far duadenal ulcer patients at reduced dasage after healing af acute ulcers.
3. The treatment af **pathalagical hypersecretary canditians** (eg, Zallinger-Ellisan syndrame and systemic mastacytasis).
4. Short-term treatment af **active, benign gastric ulcer.** Mast patients heal within six weeks and the usefulness af further treatment has nat been demanstrated.
5. Treatment af **gastraesaphageal reflux disease (GERD).** Symptamatic relief cammanly accurs within ane ar twa weeks after starting therapy and is maintained thraughaut a six-week caurse af therapy.

In active duadenal ulcer; active, benign gastric ulcer; hypersecretary states; and GERD, cancamitant antacids shauld be given as needed far relief af pain.

CONTRAINDICATIONS: ZANTAC® is cantraindicated far patients knawn ta have hypersensitivity ta the drug.

PRECAUTIONS: Symptamatic respanse ta ZANTAC® therapy daes nat preclude the presence af gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dasage shauld be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Cautian shauld be abserved in patients with hepatic dysfunction since ZANTAC is metabalized in the liver.

False-positive tests far urine pratein with Multistix® may accur during ZANTAC therapy, and therefare testing with sulfasalicylic acid is recammended.

Althaugh recammended dases af ZANTAC da nat inhibit the actian af cytachrame P-450 enzymes in the liver, there have been isalated reparts af drug interactians which suggest that ZANTAC may affect the bioavailability af certain drugs by same mechanism as yet unidentified (eg, a pH-dependent effect an absarptian ar a change in valume af distributian).

Lack af experience ta date precludes recammending ZANTAC far use in children ar pregnant patients. Since ZANTAC is secreted in human milk, cautian shauld be exercised when administered ta a nursing mather.

ADVERSE REACTIONS: Headache, sametimes severe, seems ta be related ta ZANTAC® administratian. Canstipatian, diarrhea, nausea/vamiting, and abdaminal discamfart/pain have been reparted. There have been rare reparts af malaise, dizziness, samnalence, insamnia, vertiga, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases af reversible mental canfusian, agitatian, depressian, and hallucinatians have been reparted, predaminantly in severely ill elderly patients.

In narmal valunteers, SGPT values were increased ta at least twice the pretreatment levels in 6 af 12 subjects receiving 100 mg qid IV far seven days, and in 4 af 24 subjects receiving 50 mg qid far five days. With aral administratian there have been accasianal reports af reversible hepatitis, hepatacellular ar hepatacanalicular ar mixed, with ar without jaundice.

There have been rare reports af reversible leukapenia, granulacytapenia, thrambacytopenia, and pancytopenia.

Although cantralled studies have shawn na antiandrogenic activity, accasianal cases af gynecamastia, impatence, and lass af libida have been reparted in male patients receiving ZANTAC, but the incidence did not differ from that in the general papulatian.

Incidents af rash, including rare cases suggestive af mild erythema multifarme, and, rarely, alapecia, have been reparted, as well as rare cases af hypersensitivity reactians (eg, branchaspasm, fever, rash, easinaphilia) and small increases in serum creatinine.

OVERDOSAGE: Infarmatian cancerning passible averdasage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: Active Duadenal Ulcer: The current recammended adult aral dasage is 150 mg twice daily. An alternate dasage af 300 mg once daily at bedtime can be used far patients in whom dosing canvenience is important. The advantages af ane treatment regimen campared ta the ather in a particular patient papulatian have yet ta be demanstrated.

Maintenance Therapy: The current recammended adult aral dasage is 150 mg at bedtime.

Pathalagical Hypersecretary Canditians (such as Zallinger-Ellison Syndrame): The current recammended adult aral dasage is 150 mg twice a day. In same patients it may be necessary ta administer ZANTAC 150-mg dases mare frequently. Dases shauld be adjusted ta individual patient needs, and should cantinue as lang as clinically indicated. Dases up ta 6 g/day have been emplayed in patients with severe disease.

Benign Gastric Ulcer: The current recammended adult aral dasage is 150 mg twice a day.

GERD: The current recammended adult aral dasage is 150 mg twice a day.

Dasage Adjustment far Patients with Impaired Renal Function: On the basis af experience with a graup af subjects with severely impaired renal functian treated with ZANTAC, the recammended dasage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 haurs. Should the patient's canditian require, the frequency af dasing may be increased ta every 12 haurs ar even further with cautian. Hemadialysis reduces the level af circulating ranitidine. Ideally, the dasage schedule should be adjusted sa that the timing af a scheduled dose caincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrachlaride equivalent ta 300 mg af ranitidine) are yellow, capsule-shaped tablets embassed with "ZANTAC 300" an ane side and "Glaxa" an the ather. They are available in battles af 30 (NDC 0173-0393-40) and unit dase packs af 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrachlaride equivalent ta 150 mg af ranitidine) are white tablets embassed with "ZANTAC 150" an ane side and "Glaxa" an the ather. They are available in battles af 60 tablets (NDC 0173-0344-42) and unit dase packs af 100 tablets (NDC 0173-0344-47).

Stare between 15° and 30°C (59° and 86°F) in a dry place. Pratect fram light. Replace cap securely after each opening.

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October 1986

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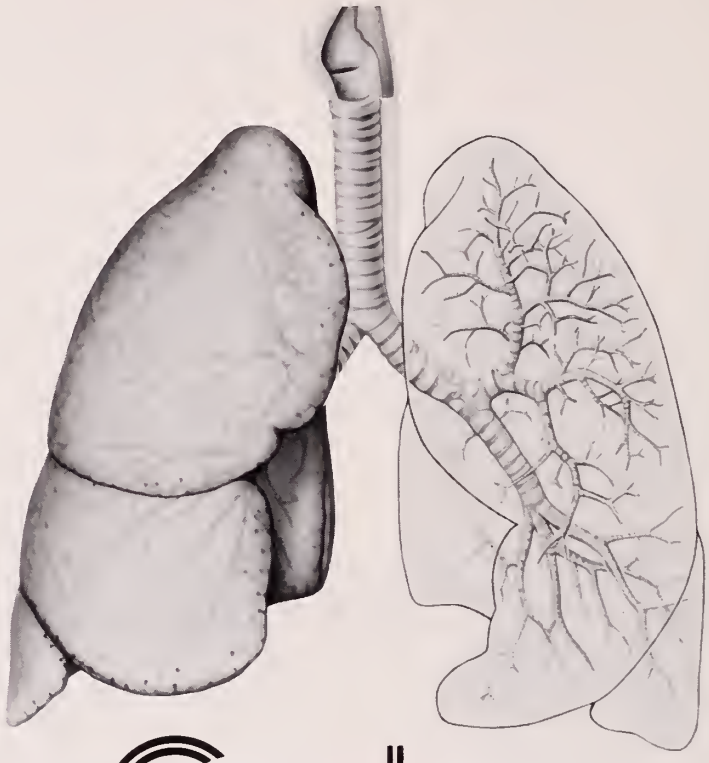
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J-6138 January 1986

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, Streptococcus pneumoniae
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

[072886R]

PA 8794 AMP

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Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

700241

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

Auxiliary Liaison Editor—**Mrs. Walter (Isabella) Laude**

Create a winning team

"The past is prologue to a future bright with promise," predicted newly installed AMA Auxiliary President, Betty Szewcyzk, as she challenged Auxilians to create a winning team to assure health and a good quality of life for all with an Auxiliary image that reflects its service. She announced goals for the coming year that include each county's doing at least one project in adolescent health, one legislative project, and one program to address the needs of medical families.

Seventeen Florida delegates (outnumbered only by Texas) attended the 1987 Chicago annual session that elected Florida's Priscilla Gerber to the Board as a Director from the Southern Region and also voted Susan Marks, FMA-A President, onto the national nominating committee.

The smoothly run convention, chaired by '86-'87 President Pat Durham, was a good one for Florida as Susan Marks accepted awards presented by this year's AMA—ERF chairman, Priscilla Gerber, for being the third highest state in total contributions both including physician donations and from the Auxiliary alone. Florida's contribution totaled more than $111,000. Pinellas and Sarasota Counties were recognized for contributions of more than $11,000 each. Delegates attended the opening of the AMA convention, where Priscilla Gerber presented the AMA-ERF president with a check for $1,901,350.64 from AMA-A.

Florida increased its membership this year and was recognized for having more than 75% of its members belonging to national.

Susan Marks chaired the Health Issues reference committee which heard testimony on projects, later approved by the House of Delegates, to promote education on the hazards of all-terrain vehicles, importance of child water safety, and prevention of elder abuse; and to support smoke-free health care facilities, mandatory seat beat laws, seat belt education, adolescent health, and promotion of AIDS education for youth.

Besides doing the business of the House, Florida delegates met Auxilians from Alaska to Connecticut to Hawaii as they shared ideas and projects.

They also heard from several famous people. John J. Coury Jr., M.D., AMA President, challenged Auxilians to enourage their spouses to understand that politics is no longer a dirty word but part of democracy. He asked for help with the problems of adolescent health and AIDS education.

Donald Rumsfeld, former Secretary of Defense and present Advisor on National Security Affairs, called voluntary organizations the ribcage of America, as he talked about courses of action the U.S. should take for military and economic stability.

Syndicated columnist and political commentator Mark Shields entertained delegates with his very humorous but insightful analysis of the U.S. political situation looking toward the '88 election.

Oprah Winfrey, talk show hostess and actress, was a hit with her entertaining comments on reaching one's dreams. Auxilians left the convention inspired to work even harder to make their dreams of good health come true for all people.

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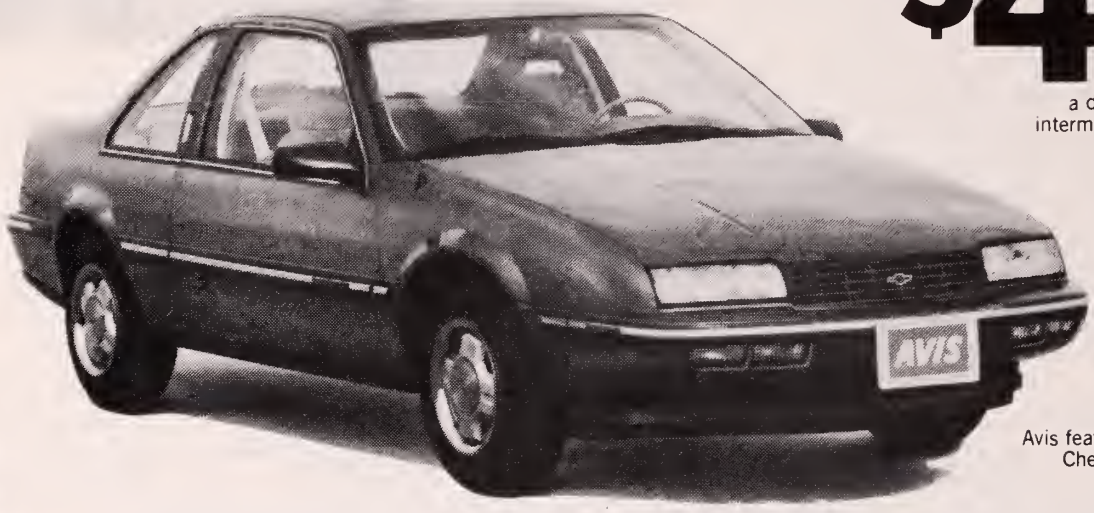
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Harvard Medical School and Harvard School of Public Health

Dr. William J. Curran is a noted authority on Risk Management and Malpractice. His activities include:

- *Member of the National Medical Malpractice Commission*
- *Legislative Drafting and Research*
- *Instructor of Risk Management, Malpractice and Compensation Systems Course at Harvard in cooperation with Harvard (Hospital) Risk Management Foundation*
- *Contributing columnist for* "Law Medicine Notes," *New England Journal of Medicine;* "Public Health and the Law," *American Journal of Public Health*

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Program content and discussion will consist of the following elements: 1) medical malpractice in Florida—a current update and evaluation; 2) orientation to medical malpractice and risk management; 3) problems and pitfalls in malpractice for practitioners; 4) malpractice prevention and risk management; 5) principles of risk management; 6) hospital programs of risk management; and 7) practical applications of risk management systems in Florida.

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To receive additional information contact: (305) 547-6716 or clip and mail the following:

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Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

SEPTEMBER

Ambulatory Updates in Family Practice, September 5-7, Ritz-Carleton Hotel, Naples. Contact: Stephen Kaskie, M.D., 28111 U.S. 41, S.E., Bonita Springs, FL 33923. (813) 992-7000.

Medical Risk Management, September 12, Location TBA. Contact: Ronna Davis, P.O. Box 12099, Tallahassee, FL 32317. (904) 385-4935.

Annual Pediatric Symposium — 1987, September 4-6, Sacred Heart Hospital, Pensacola. Contact: Barabara J. James, (904) 477-4956.

Risk Management Seminar, September 10, The Winecellar Restaurant, North Reddington Beach. Contact: John Wilhelm, M.D., P.O. Box 4001, Seminole, FL 33542. (813) 393-4646, ext. 159.

Doppler Echocardiography Seminar, September 10-12, Innisbrook Resort Conference Center, Tarpon Springs. Contact: Registrar, Ultrasound Center, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, N.C. 27103. (919) 748-4505.

Magnetic Resonance Imaging: A Technologist's New World, September 10-12, Peabody Hotel, Orlando. Contact: Martin Silbigu, M.D., (813) 974-2538.

Clinical Update-Health Behavior and Disease, September 12, Tampa Marriott Westshore, Tampa. Contact: R.M. Bhatty, M.D. at (813) 237-3914.

Medical Risk Management, September 12, TBA, St. Pete. Contact: Ronna Davis, P.O. Box 12099, Tallahassee, FL 32317 or phone (904) 385-4935.

Clinical Update—Health Behavior and Disease, September 12, Tampa Marriott Westshore, Tampa. Contact: R.M. Bhatty, M.D., (813) 237-3914.

Fractures of the Pelvis and Acetabulum, September 12-19, Paris, France. Contact: Emile Letournel, M.D., (813) 974-3322.

Medical Malpractice, Prevention & Defenses, September 15-16, Miami Beach. Contact: Mt. Sinai Medical Center, Attn: CME Coordinator, 4300 Alton Rd., Miami Beach, FL 33140. (305) 674-2311.

FMA Annual Meeting Scientific Program, September 16-20, Diplomat Hotel, Hollywood. Contact: Robert Fore, Ed.D., 760 Riverside Avenue, Jacksonville, FL 32204. (904) 356-1571.

Traumatic Spinal Cord & Head Injury, September 17-18, Hilton Hotel, Pensacola. Contact: Phyllis Connerley, P.O. Box 18900, 8383 N. Davis Hwy., Pensacola, FL 32523-8900. (904) 478-4460 ext. 4178.

Pediatrics for the Practitioner, September 18, Sheraton Tampa East, Tampa. Contact: H. Pomerance, M.D., (813) 974-4214.

Comprehensive Course in Small Incision Phacoemulsification Cataract Surgery, September 18-19, Indigo Lake Resort, Daytona Beach. Contact: Albert Neumann, M.D., (904) 734-4431.

Current Concepts in the Diagnosis and Management of Adult Heart Disease, September 18-19, New World Landing, Pensacola. Call: (904) 478-4460.

Urology for the Non-Urologist, September 19, Jacksonville Marriott, Jacksonville. Contact: Marie Tyne (904) 355-6583.

Wellness & Aging, September 23-24, Hilton Hotel, Gainesville. Contact: William C. Thomas Jr., M.D., VA Medical Center, Archer Rd., Gainesville, FL 32602. (904) 374-6077.

Risk Management Seminar, September 26, Good Samaritan Hospital, W. Palm Beach. Contact: Barbara Brezner, P.O. Box 3166, W. Palm Beach, FL 33402. (305) 650-6236.

ACLS Provider Course, September 26-27, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D., (813) 251-6911.

OCTOBER

The Friary's Sixth Annual Professional & Chemical Dependency Seminar, October 2, Pensacola Beach. Contact: Brunie Emmanuel, (904) 932-9375.

Emerging Trends in Critical Care—1987, October 7-9, Crowne Plaza Hotel, Orlando. Contact: Rick Mace, (305) 897-1575.

Medical Risk Management, TBA, Miami. Contact: Ronna Davis, P.O. 12099, Tallahassee, FL 32317. (904) 385-4935.

After the Golden Hour, October 9, Hilton Hotel, Pensacola. Contact: Robert Ruby, M.D., 1201 W. Moreno St., Pensacola, FL 32501. (904) 434-4819.

Cardiopulmonary Update, October 9-11, Marriott at Sawgrass, Ponte Vedra Beach. Contact: Alberta Hipps, 1800 Barrs St., Jacksonville, FL 32203. (904) 387-7563.

All America's Health '87, October 15-18, Curtis Hixon Convention Center, USF College of Medicine. Contact: P.J. Bouis Jr., M.D. (813) 974-4296.

International Symposium on Gynecologic Oncology, Surgery and Urology, October 18-23, Japan. Contact: Patti Mundy, (305) 549-6944.

Thirteenth Annual Panamerican Seminar, October 19-23, Mt. Sinai Medical Center, Miami Beach. Contact: Mt. Sinai Medical Center, Attn: CME Coordinator, 4300 Alton Road, Miami Beach 33140. (305) 674-2311.

Magnetic Resonance Imaging, October 19-23, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

13th Annual Panamerican Medical Seminar, October 19-23, Mt. Sinai Medical Center, Miami Beach. Contact: Federico Justiniani, M.D., 4300 Alton Rd., Miami Beach, FL 33140. (305) 674-2311.

Fall 1987 Familly Practice Review, October 19-23, Peabody Hotel, Orlando. Contact: Grace Wagner, JHMHC J-233, Gainesville 32610. (904) 392-4321.

A Case Study Approach to Risk Management and Malpractice, October 23, Sheraton, Bal Harbour. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

Thirteenth Annual Gulf Coast Internal Medicine Conference, October 23-24, New World Landing, Pensacola. Contact: Dr. Garth Grove at (904) 474-7101.

45th Regional Family Practice Weekend-Miami, October 23-25, Miami Airport Hilton, Miami. Contact: Charles A. Dunn, M.D., 1627 Rogero Rd., Jacksonville, FL 32211-4866. (904) 743-6304.

Current Concepts in Wound Healing and Photography for Cutaneous Surgery, October 27, Boca Community Hospital, Miami. Contact: Larry Garland, M.D., Dept. of Derm., U. of Miami, P.O. Box 016960, Miami, FL 33101. (305) 547-4477.

Current Concepts, October 27, Boca Community Hospital, Boca Raton. Contact: Larry D. Garland, M.D., P.O. Box 016960, Miami, FL 33101. (305) 547-4477.

28th Workshop in Electrocardiography, October 28-31, Sheraton Sand Key, Clearwater Beach. Contact: Henry Marriott, M.D., (813) 894-0790.

5th Annual Advanced Neuroradiology, October 29-31, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, (813) 974-2538.

A Case Study Approach to Risk Management and Malpractice, October 31, Contemporary Hotel in Walt Disney World. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami, FL 33101. (305) 547-6716.

Medical Risk Management, TBA, Tampa. Contact: Ronna Davis, P.O. Box 12099, Tallahassee, FL 32317. (904) 385-4935.

NOVEMBER

Internal Medicine Update '87, November 1-6, The Colony Beach Resort, Sarasota. Contact: Murray Grossman, M.D., (315) 473-4606.

Primary Care Update: 72nd Scientific Assembly, November 2-5, Diplomat Hotel, Hollywood. Contact: Ray W. Giffor Jr., M.D., (608) 257-6781.

13th Annual Obstetrics and Gynecology Review Course, November 3-11, Doral Hotel on the Ocean, Miami. Contact: Patti Mundy. (305) 549-6944.

Advanced Applied Ultrasound in Obstetrics, November 5-7, Bowman Gray School of Medicine, Naples. Contact: Regsitrar, Ultrasound Center, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, N.C. 27103 or call: (919) 748-4504.

Neonatal & Pediatric Respiratory Disease Conference, November 5-8, Sheraton Sand Key, Clearwater Beach. Contact: R. Lawrence Siegel, M.D. (813) 972-3131.

American Heart Association ACLS Instructor Course, November 7-8, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

13th Annual Ob/Gyn Pathology Review, November 12-15, Doral Hotel on the Ocean, Miami. Contact: Patti Mundy (305) 549-6944.

Nutrition in Pediatric Practice, November 13, Sheraton Tampa East, Tampa. Contact: Herbert Pomerance, M.D., USF Dept. of Pediatrics, 12901 Bruce B. Downs Blvd., Box 15CE, Tampa, FL 33612. (813) 974-4214.

The Distal Radioulnar Joint, November 13-14, Orlando. Contact: Paula Scheid, 3025 S. Parker Rd., Suite 65, Aurora, CO 80014. (303) 755-4588.

Flexible Sigmoidoscopy, November 14-15, Sonesta Beach Hotel, Key Biscayne. Contact: John P. Christie, M.D., (305) 687-1367.

All America's Health '87, November 15-18, Curtis Hixon Convention Center, Tampa. Contact: Pierre J. Bouis Jr. M.D., (813) 974-4296.

11th Annual Seminar of the Florida Association of Pediatric Tumors, November 19-21, Holiday Inn Crown Plaza, Orlando. Contact: Cindi Butson, P.O. Box 13372, University States, Gainesville, FL 32604. (904) 375-6848.

Small & Large Defects, How I Repair Them, November 24, Boca Community Hospital, Boca Raton. Contact: Larry D. Garland, M.D., P.O. Box 016960, Miami, FL 33101. (305) 547-6716.

DECEMBER

Clinical Allergy & Immunology for the Practicing Physician, December 3-5, Buena Vista Palace, Lake Buena Vista. Contact: Richard F. Lockey, M.D., (813) 972-7631.

1987 Neuro-Opthalmology Course, December 3-5, Key Biscayne Hotel, Key Biscayne. Contact: Goby Kressly (305) 326-6031.

Diagnosis & Management of Respiratory Diseases, December 4-6, Boca Raton Hotel, Boca Raton. Contact: Karen DeBont, (800) 421-3756.

1987 FINA World Medical Congress, December 5-8, Justus Aquatic Center/Radisson Hotel, Orlando. Contact: Allen Richardson, M.D., (303) 578-4575.

Emergencies in Internal Medicine, December 6-12, St. Thomas, Virgin Islands. Contact: Laurence B. Gardner, M.D., P.O. Box 016960, Miami, FL 33101. (305) 547-6716.

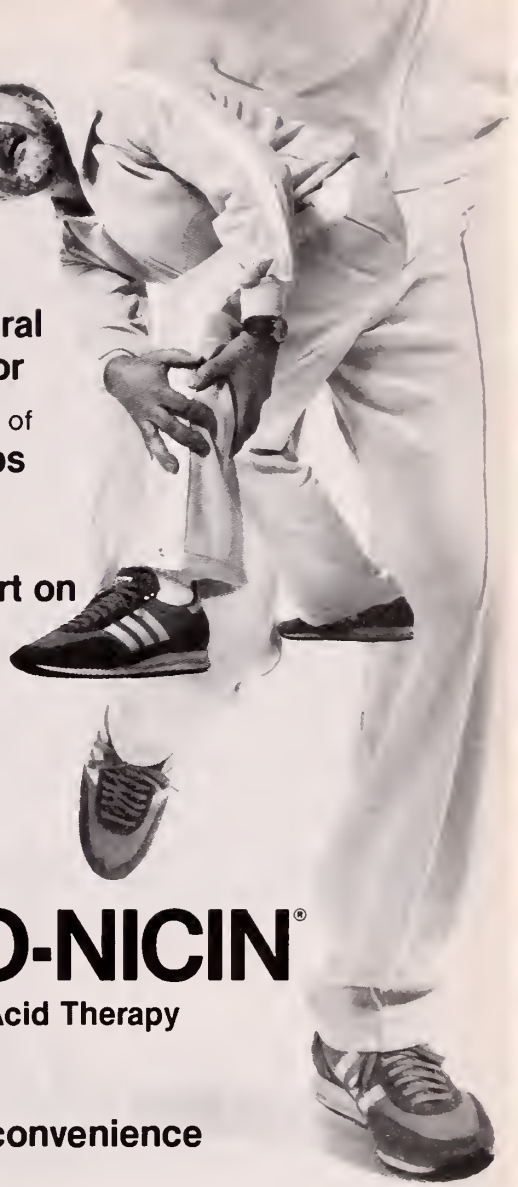
A Case Study Approach to Risk Management and Malpractice, December 18-19, Sheraton, Bal Harbour. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

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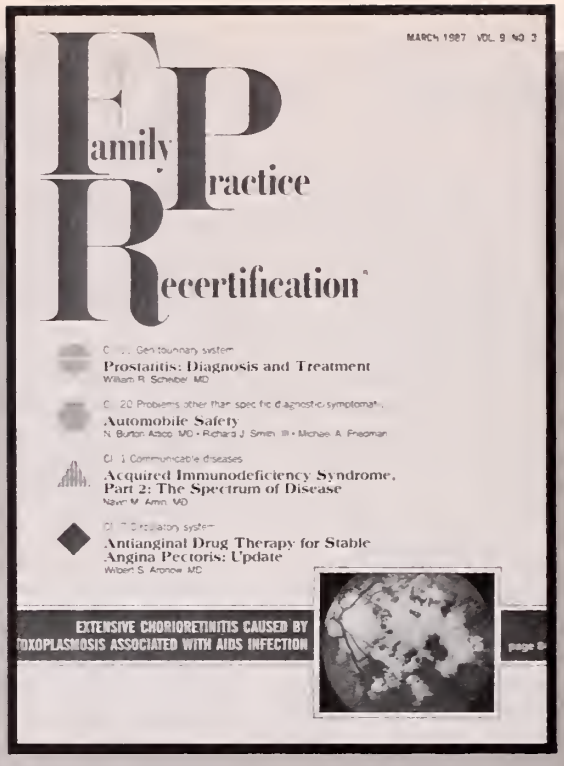
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AVAILABLE IMMEDIATELY full or part-time. May have hospital in-patients or out-patient practice only. Large family practice. Partnership available after one year. Excellent salary and fringes. Located Florida's Gulf Coast between Tampa and Fort Meyers. Send CV to: P.O. Box 537, Venice, FL 34285 or call (813) 485-4858.

FLORIDA (Jacksonville)-Clinic based General Pediatrician with special interest in Community Pediatrics and handicapped children. U.S. trained and Board eligible, plus current eligibility for Florida license. Contact P. E. Findlay, M.D., Nemours Children's Clinic, P.O. Box 5720, Jacksonville, FL 32247. Or call collect at (904) 390-3627.

EMERGENCY MEDICAL GROUP, a progressive, physician-owned organization is seeking Full and Part-time Board certified/eligible and Family Practice physicians for openings in Southeast Florida. Competitive salary, paid malpractice insurance, benefits and attractive scheduling. Send CV to Emergency Medical Group, 1400 NW 12th Ave., Miami, FL 33136.

ACTIVE, ESTABLISHED AMBULATORY CARE CENTER seeking Board Certified Family Practice or Emergency Physician for full-time work. Excellent community. Diverse outdoor recreation, excellent schools and housing values. Superior working environment-no night call. Class "A" malpractice category in "low-risk" area of Florida. 48 hours/week $103,000. Please contact: Douglas Sherman, M.D. or Bill Riddle at Physician Care (904) 386-2266.

WANTED: PEDIATRICIAN to join a young but busy solo private practice in pretty community near Disney World and Beaches. Excellent Regional Hospital. Send CV to Box C-1402, P.O. Box 2411, Jacksonville, FL 32203.

BC/BE OB/GYN needed for Colquitt Regional Medical Center in Moultrie, DA to replace retiring OB/GYN physician. Guaranteed package and highly competitive. In an average year we deliver 520 babies and do 282 GYN surgeries. Contact: Dr. Norman Reese (912) 985-3420 ext. 357.

DAYTONA: Full-time opportunities available for board prepared emergency physicians in this 200-bed hospital. Beautiful Daytona Beach speaks for itself. For further information contact: Cheree Richards, EMSA, 100 N.W. 70th Ave., Plantation, FL 33317 or call collect at: (305) 584-1000.

PSYCHIATRIST: Excellent opportunity for board certified or eligible psychiatrist. This position provides the advantage of being able to establish a vital practice with minimal inital investment. Broad range of fee-for-service delivery within well-established referral network serving lovely waterfront communities. Reply to P.O. Box 2068, Cape Coral, FL 33904 or call (813) 772-9099.

INTERNIST OR FAMILY PRACTITIONER BE or BC to join busy solo practitioner 10 miles north of Clearwater. Salary plus benefits. Please send CV to Physician. P.O. Box 1614, Palm Harbor, FL 33563.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

ALL SPECIALTIES SOUGHT for various client opportunities throughout the southeastern U.S. Amb. care, HMOs, multi-single specialty groups, partnerships, sold. Needed especially are: IM, FP, EM, DERM, CARD, ENT, ORS, GS. All positions provide excellent financial incentives in attractice/coastal locations. For details call collect (813) 621-7331 or (904) 799-2224 or send CV in confidence to: SPR, Inc., P.O. Box 11337, Tampa, FL 33680.

SHENANDOAH VALLEY OF VIRGINIA: Shenandoah County Memorial Hospital of Woodstock, Virginia is looking for physicians--OB/GYNs, Family Practice, ENTs, Orthopedic Surgeons, General/Vascular Surgeons--to practice in our expanding community. A 133 bed acute care community hospital, SCMH is located in the beautiful Shenandoah Valley/Blue Ridge Mountain area of Virginia, just 90 minutes west of Washington, D.C. High income potential and LOW MALPRACTICE RATES (see our display ad on page 641 for complete list of rates.) Call the Office of Administration at (703) 459-4021, Ext. 457, or send CV to: Administrator, Shenandoah County Memorial Hospital, P.O. Box 508, Woodstock, Virginia 22664.

DIRECTOR PHYSICAL MEDICINE AND REHABILITATION: 21 bed in-house unit at 500+ bed major medical center on SE Florida coast. Metro amenities, excellent housing, schools and universities. Directorship, marketing experience a plus. 2 year guarantee plus stipend, relocation, overhead. Contact Sandy. Tyler & Co., 9040 Roswell Rd., Atlanta, GA 30338 or call collect: (404) 641-6411.

FAMILY PHYSICIAN: BC or BE for West Palm Beach practice. FL license necessary. Opportunity for future partnership. Call: (305) 967-0234.

TIRED OF HMOs? Conduct your specialty or primary care practice in a traditional setting in a growing community south of Ocala. Demand for all specialties exceeds supply (AMA market profile available). The new Mockingbird Hill Professional Center is now open with lease/purchase option. Opportunity now exists for custom interior design. Lab and x-ray on-site and private ambulatory care center provides a referral base. Only 10 min. drive to HCA hospital. For information call or write Carol Roberts, Care-1, Inc., 1805 S.E. Lake Weir Ave., Ocala, FL 32671 or (904) 351-0789.

BOARD CERTIFIED GENERAL SURGEON, as associate, private practice in Orlando. Send CV, references, photo to Box C-1366, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTITIONER - CENTRAL FLORIDA: Position available in Central Florida for a residency trained, Board eligible or certified Family Practitioner, to join our 4 other FPs in a 30-man multispecialty group. Excellent starting salary with benefits. Please send CV with picture to G. J. Rafool, M.D., Gessler Clinic, 635 1st St., North, Winter Haven, FL 33881.

GENERAL MEDICINE—Primarily internal medicine, family practice and geriatrics. Part-time associate wanted. can lead to full-time position if desired. No night call or weekends. Located in Largo, FL., 2 miles from Gulf beaches. Salary negotiable. Perfect position for semi-retired physician or physician starting practice. Contact: R. Chris Brown, M.D., 1890 W. Bay Drive., Largo, FL 34640. (813) 585-5190.

FLORIDA LICENSED physician for Family practice activities. Public Health background helpful. Reply: Collier County Health Dept., Director's Office, P.O. Box 428, Naples, FL 33939. (813) 774-8210.

B/C or B/E INTERNIST wanted for busy, established in practice in beautiful resort community on Florida's west central coast. Opening immediately available. Financial renumeration negotiable. Unique opportunity for the right individual. Respond to: Box C-1412, P.O. Box 2411, Jacksonville, FL 32203.

DIAGNOSTIC RADIOLOGIST —Board certified with FL license. Experience with M.R.I. and interventional procedures necessary. Will consider neuroradiologist with similar experience. Hospital practice and two private offices. Send C.V. to c/o P.O. Box 599, Roseland, FL 32957-0599.

DAYTONA BEACH, FL — Freestanding walk-in medical treatment center. We are seeking a caring family physician, general practitioner or emergency medicine physician. Full-time physician wanted for busy walk-in Medical Treatment Center in a rapidly growing area. Less than 40 hr work week, excellent salary, fringe benefits, practice coverage and modern facilities. For more information contact: Carolyn Hood, Office Mgr., 1130 Beville Rd., Daytona Beach, FL 32014. (904) 253-6051.

ST. AUGUSTINE, FL — OB/GYN male/female, American trained, to join Board Certified OB/GYN and Certified Nurse Midwife in free standing, fully equipped Woman's Center. Beautiful rapidly growing community on Atlantic Ocean. Ideal climate, located 35 miles from Jacksonville. Now's the time to move to Florida. Send resume or call: Anthony J. Mussallem, M.D., P.A. 2 St. Augustine South Dr., St. Augustine, FL 32086. (904) 797-3785.

OBERLIN, OH 20 person multispecialty group seeks additional BC/BE family physicians, internist, cardiologist, OB/Gyn and otolaryngologist. North central Ohio college town serving drawing area of 290,000. Salaried position first year; full shareholder status available in second year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074.

OB/GYN, ORTHOPEDIC surgery, family practice, internal medicine opportunities. Bernie Hoffmann Associates, Inc., a Nationwide Health Care Consulting Firm, is currently assisting major midwest health care providers in their search for physicians in the aforementioned specialties as well as others. All opportunities offer paid malpractice, attractive income guarantees with incentives and comprehensive fringe benfit packages. All inquiries will be handled in the strictest confidence. Please forward c.v. or call Damian Kozak or John Rafferty, Bernie Hoffmann Associates, Inc., 20755 Greenfield, Suite 601, Southfield, MI 48075. (313) 557-9340.

FAMILY PRACTICE PHYSICIAN for Primary Care Center — Central Florida East Coast. Hospital affiliated with excellent potential for income and professional growth. Send CV to J.A. Sasser, M.D., 951 N. Washington Ave., Titusville, FL 32796. (305) 268-6556.

BC/BE FAMILY PRACTICE or Internists needed in Lee County, FL. Career opportunity; office & hospital practice in new office. Attractive financial package with option to buy in full or part. Send resume to: MED-CENTER PLAZA GROUP, INC., Attn: Martin E. Dolence, Jr., CPA, 6314 Corporate Ct., #C, Ft. Myers, FL 33907 or call for an appt. (813) 489-2227.

THE DEPARTMENT OF pathology is seeking an Assistant Professor in Pathology. Candidate must have a Ph.D. in a biological science with a minimum of 6 years' postdoctoral experience in basic science research. This individual will be responsible for the basic science teaching and training of graduate students within the Experimental Pathology Program and teaching within the medical student pathology courses. This individ will be expected to carry out an independent, externally funded, research program in the area of molecular genetics of hematopoietic malignancies. As this will be the primary activity of this individual, demonstrated success in this area is required. Clinical service responsibility, to be shared with the present faculty of the Division of Hematopathology, will be the professional service, management and development of a clinical molecular biology laboratory for Shands Teaching Hospital at the University of Florida and related patient care areas. deadline for recruiting is 8/30/87 with a starting date of 9/1/87. Applicants should send CV to Raul C. Braylan, M.D., Professor, Dept. of Pathology, Box J-275, JHMHC, University of FL., Gainesville, FL 32610. Equal Opportunity/Affirmative Action Employer.

UNIQUE OPPORTUNITY FOR PHYSICIANS: Private practice of your specialty (exclusives given) Ocean Medical Center, Since 1969, serving affluent population of 40,000 in Galt Ocean Mile/Adjoining Beach Area. Urgently needed: Cardiologist, Plastic S., Pul. and Rheum. No salary, but will help with office rent. Call Collect: (305) 776-5800. 4001 Ocean Dr., Lauderdale-by-the-Sea, FL. Florida licensure mandatory.

WANTED: Certified Specialists in the field of Proctology, Radiology and General Surgery to review medical records and to be available for court testimony. Send your CV to 118 Olympus Way, Jupiter, FL 33477. Or Call (305) 575-0505 or (800) 223-5981.

URGENT NEED: FL license doctors to fill needs of rapidly growing west coast community. Family Practice and internist. ALl hospitals are open staff. Send CV to P.O. Box 2411, Box C-1408, Jacksonville, FL 32203.

FAMILY PRACTICE: Opportunity to join three board certified F.P.s in a rapidly growing practice at the Beach. Excellent community to live and grow. Next to a large metro area. Practice is strong in wellness, preventive and psychosocial medicine. Salary negotiable with opportunity to buy in. Contact: North Beach Family Practice, Attn: Dr. R. D. Gottula, 100 Royal Palm Dr., Atlantic Beach, FL 32233. Or call (904) 241-5107.

THE VETERANS ADMINISTRATION, Medical Center, Lake City, FL is recruiting for a board certified Psychiatrist. Will assist in estblishment of new Service in a progressive environment of inpatient and outpatient activity. Competitive salary plus incentive pay commensurate with qualifications. Liberal benefits plus malpractice insurance and retirement program. The North FL area offers an excellent climate year round, extensive outdoor recreational activities, lower than average cost of living, fine schools and nearby university, local community college, uncongested commuting to Medical Center. Contact John H. Beggs, M.D., Chief of Staff, VA Medical Center, Lake City, FL 32055, (904) 755-3016, Ext. 2011. An Equal Opportunity Employer.

SITUATIONS WANTED

FAMILY PRACTICE PHYSICIAN: Board certified, Florida licensed, with extensive clinical experience in primary care, seeking employment opportunity. Available now, part or full time. Call: (305) 721-1978. Job must be within driving distance of Ft. Lauderdale. Or Write to: Henry Friedensohn, M.D., 3404 Willowwood Rd. Lauderhill, FL 33319.

WANTED: INTERNAL MEDICINE or family practice in Palm Beach County or North Broward Counnty. Other exceptional practices also considered elsewhere in Florida. Call: (305) 622-7661, (305) 831-9305, Work: (313) 745-5111, Beeper: 8272.

EXPERIENCED NEUROLOGIST, BC, with 4 yrs' experience performing and interpreting MRI & CT of head and spine as well as carotid ultrasound. Seeks affiliation with group needing expertise in these areas. Reply to Box C-1403, P.O. Box 2411, Jacksonville, FL 32203.

YOU DESERVE THE BEST from your practice. Sell it with confidence of receiving top dollar and obtaining the best physician for your patients. Quality and personal attention are our expertise. We can help you now. Call Frank B. Lane, M.D., Medical Dir., Medical Consultants of America, at (813) 968-3878. Also private practice opportunities available.

VASCULAR/GENERAL SURGEON: Board Certified General Surgeon with two-year Vascular Surgery Fellowship. Seeking private practice affiliation with busy group. Florida license; native of South Florida. Available July 1988. Write: P.O. Box 2411, Box C-1411, Jacksonville, FL 32203.

LICENSED FLORIDA M.D. skilled in General Practice Board Certified OB/GYN. 25 years experience in private practice in Miami. 20 years chief of gynecology. Sick of threat of malpractice. Desires work in Miami with a hospital; HMO, insurance company, private group, cruise line, or will head a medical department or assist. Reply to: Box C-1403, P.O. Box 2411, Jacksonville, FL 32203.

HEMATOPATHOLOGIST, Board certified in clinical-anatomic pathology, has both clinical and research experience and Florida MD license. Seeks laboratory, hospital or group practice position. Write: Box C-1392, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE — Board Certified FL license, looking for private practice opportunity (solo, partnership, group) in Orlando. Willing to buy. Write: Box C-1415, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST WITH SUB-SPECIALTY training and FL license wishes to relocate along east coast. Write to Box C-1398, P.O. Box 2411, Jacksonville, FL 32203.

PRACTICES AVAILABLE

INTERNAL MEDICINE PRACTICE FOR SALE: 80 miles south Disney World, in central Florida. Retiring 28 years. Holter Monitor, Fiberoptics, complete lab, etc. Will introduce. Prefer Cardiologist or gastroenterologist. P.O. Box 2411, C-1418, Jacksonville, FL 32203.

OIAL large general practice and clinic for sale by GP preparing for retirement. Practice is part of a progressive and rapidly expanding community located in central Minnesota near excellent winter and summer recreation. Current clinic grosses more than $500,000 annually, is expandable and equipped with surgery, X-ray, lab and set up for pharmacy. Fee for service and growing! Malpractice insurance not a serious problem. Computerized, excellent staff. Great potential for aggressive GPs, FPs, internists or surgeons. Excellent hosptial one mile. Contact: Janet K. (612) 251-9191.

INTERNAL MEDICINE PRACTICE FOR SALE: in N.E. FL., well-established, excellent gross, will introduce. Write: Box C-1401, P.O. Box 2411, Jacksonville, FL 32203.

NORTH CENTRAL FL., General surgical practice, very active, conveniently located to hospitals. Due to contemplated retirement, would like to sell to two qualified general surgeons. Reply to Box C-1405, P.O. Box 2411, Jacksonville, FL 32203.

COASTAL PALM BEACH COUNTY established ophthalmology (anterior segment surgical) practice for sale. Office Surgical Suite, high gross, cost recoverable one year. Reply with CV to Box C-1397, P.O. Box 2411, Jacksonville, FL 32203.

RETIRING BOARD CERTIFIED OB/GYN selling or leasing completely equipped office. Capacity for 2 or more OB/GYNs. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone: (305) 667-3677.

FAMILY PRACTICE FOR SALE: High volume family practice, west coast of Florida, South of Tampa/St. Pete. Suitable for two physicians. Eight exam rooms all fully equipped, lab, x-ray, computerized business office. Expanding area, two local hospitals. For further information, contact Box C-1361, P.O. Box 2411, Jacksonville, FL 32203.

INTERNAL MEDICINE PRACTICE FOR SALE: N.E. FL, well established, excellent gross. Will introduce. Write: Box C-1396, P.O. Box 2411, Jacksonville, FL 32203.

ACTIVE, WELL-ESTABLISHED, General Practice with bldg for sale. Gross $180,000 to $200,000 a year. Can be improved. Ideal for minority physician. FL Gold Coast. Write to: Box C-1413, P.O. Box 2411, Jacksonville, FL 32203.

ORTHOPEDIC PRACTICE FOR SALE. Excellent opportunity in general orthopedics, trauma, joint replacements, arthoscopy and back surgery for qualified physician. Lake City, FL. Write Box C-1414, P.O. Box 2411, Jacksonville, FL 32203.

MIAMI BEACH AREA. Long established solo practice Excellent terms. (305) 865-8747.

PRACTICE OPPORTUNITIES for family practice or emergency physicians in ambulatory care centers. Competitive hourly fee with economic incentives. Association with hospital E.D. Contact: Dr. Robert Schiffer, MRMC, P.O. Box 6000, Ocala, FL 32678. Call (904) 351-7600.

OFFICE SPACE AND USE of playroom available in already established office at 4113 Bridgeport Way West in Tacoma, Washington. Desirable area for establishing a practice in the area of child, family and general psychiatry for a Psychiatrist who is interested in developing his/her own practice in conjunction with psychiatric evaluations and medication assessment of children, adolescents, and adults (mostly women). Please contact Vivian L. Ehly, R.N., B.S., M.S., for further information at (206) 564-0152.

GENERAL PRACTITIONER contemplating retirement. Rental situation: no real estate. Records, equipment, receptionist available. Terms reasonable. Sarasota. Write: P.O. Box 2411, Box C-1417, Jacksonville, FL 32203.

TIRED OF HIGH MALPRACTICE PREMIUMS? Retiring Family Physician with lucrative Family Practice (no obstetrics) for sale in Zanesville, OH, approx. 55 miles east of Columbus. A city of 37,000 with a drawing area of 150,000 plus, and is known as the medical center of Southeastern, OH. Two excellent and well-equipped hospitals. LOW DOWN PAYMENT with assistance in financing. Telephone evenings after 5:00 p.m. or weekends at (614) 453-1422.

GENERAL PRACTICE — Northeast Florida. Retiring physician wishes to sell 15 year old practice. Average income last three years $150,000. Unlimited potential - growing beach community. Call (904) 739-3300 Eileen Cox.

REAL ESTATE

NORTH CAROLINA MOUNTAINS REAL ESTATE: Sacrifice, must sell 3-year-old dream house in Blowing Rock with magnificent 280° view overlooking Appalachian mountain ski slopes. Customer decorator appointed features throughout this 3bdr, 2½ bath all cedar home. Includes Jacuzzi, billiard table, brick hearth with Jenn-Aire, gold plated plumbing fixtures, teakwood foyer, heartshaped fireplace, wet bar, red oak kitchen cabinets, red oak plank flooring in game room, triple pane glass throughout, vaulted solid pine ceilings, 1,530 feet of wraparound decks and double garage. $250,000. Furn. Color photos available to the serious buyer upon request. Days: (704) 262-0009, Evenings call (704) 295-3939.

ORANGE PARK: medical building attached to Humana Hospital. 1,300 sq. ft. (and up) medical suites for lease. Excellent parking. Minutes to Jacksonville, quality building. P.O. Box 2639, Orange Park, FL 32067. (904) 276-5362.

MEDICAL OFFICE FOR SUB-LEASE in N. Palm Beach (on US Hwy. 1). Fully equipped with laboratory, X-ray, ECG, treadmill, low rent. (305) 627-3130.

PINE TREE FARM SALE: 1,090 rolling acres. 3/4 miles paved highway frontage and 2 miles county maintained dirt road frontage. Madison, FL. Call (904) 973-6030.

RADIOLOGY OFFICE FOR LEASE, Sale or joint venture rapidly growing area, hospital and 3 medical building complex: 30 plus physicians. Write: P.O. Box 2411, Box C-1384, Jacksonville, FL 32203.

MIDTOWN MEDICAL CENTER, 333 41st St., Miami Beach, FL. Close proximity to: Miami Heart Institute, Mount Sinai Hospital. Now taking applications for medical office space available in September, 1987. Associated Realty Management, 5880 Commerce Lane, Miami, FL 33143. (305) 284-1035.

OFFICE SPACE TO SHARE with one or two physicians. 3,500 sq. ft. Full laboratory. X-ray machine. Excellent North Palm Beach location. Terms negotiable. Call John A. Swenson, M.D., (305) 844-2553.

OFFICE SPACE AVAILABLE to share immediately. 1,000 sq ft, 4 exam rooms, lab located in Piedmont Plaza, SR 436, Apopka, FL. Call (305) 886-2050.

SERVICES

UNSECURED LOANS: No collateral, confidential, $5,000 to $60,000, competitive rates, no points, no repayment penalties. Information, application, Call (800) 331-4952, Department 32 or write: P.O. Box 9739-J, Pompano, FL 33075.

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

DISTRIBUTORS, BUYERS, of High Technology Diagnostic Medical Intruments. Holters, Scanners, Ultrasound, EKGs, ICU monitors, Defibrillators, Laboratory Equipment. New or reconditioned. Contact: New Life Systems, Inc., P.O. Box 8767, Coral Springs, FL 33075. Or call (305) 972-4600 or (800) 330-TELL.

EQUIPMENT

X-RAY MACHINE: Raytheon Medical Systems FT-35 with Fischer processor. Two years old in excellent condition. Call (813) 729-6818.

MEDICAL LABORATORY WANTED: A Pathologist wishes to buy a medical laboratory. Partnership will also be considered. Please write to: P.O. Box 2411, Box C-1419, Jacksonville, FL 32203.

HOLTER MONITOR: Quality scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretation, scan price $35.00. Recorders loaned, leased or purchase new dual-channel holter recorder, $750.00 with two year warranty. For more information call collect, Advance Medical & Research Center, Inc., (313) 373-1199.

DISCOUNT HOLTER SCANNING SERVICES starting at $35. Spacelabs holter recorders available from $1,275. Smallest and lightest holters update. Fast service (24 to 48 hours) turn-over. Hook-up kits starting at $4.95. Special introductory offer of three free tests at the purchase of lease of the holter. Street test electrodes available at .34¢. Scanning paper available at $18.95. Cardiologist over-read available at $15. If interested, call (800) 248-0153.

FOR SALE—COMPLETE State-of-the-art, non-invasive, peripheral vascular laboratory: L.S.I., Inc., PVR-IV with auto-inflate, D-II bidirectional doppler, OPG-I, and all cuffs and accessories; CPA; Vascular Diagnostic Computer; Quinton 14-44-J 2-speed treadmill; and foot pillow. Sturday, solid oak, black, vinyl-upholstered examining table with step stool. Biosound Phase I, reltime, B-moide, high resolutioin, ultrasonic imager (the best ever made) with Tektronix 634 monitor and C-28 Polaroid camera, duplexed with Angioscan-I spectral analyzer with Tektronix 634 monitor and C-28 Polaroid camera for hard copy. All equipment in good working order and presently in use. Instruction pamphlets and some supplies included. Will instruct in use of equipment, operation of laboratory, and in billing. Original costs approximately $150,000. Asking $45,000. Write Box C-1409, P.O. Box 4211, Jacksonville, FL 32203.

BURCHICK E200 EKG machine in very good shape, $1,500. IBM copier, $800. Other office equipment available. Call: V. Salib (305) 267-3773 after 5:30 p.m.

MEETINGS

MEDICAL RISK MANAGEMENT seminar, August 8, Buena Vista Palace, Orlando. Contact: Medical Risk Management, Inc. (904) 385-4935.

BIOFEEDBACK THERAPIST training workshop-Eight day program to train health professionals to provide effective biofeedback therapy. Many jobs available. Training site luxury beachfront hotel. Medical, Psychology, Nursing & BCIA CEUs available. Part 1-Sept. 19-21; Part 2-Sept. 22-26, 1987, or Part 1-Nov. 14-16, Part 2-Nov. 17-21, 1987. Computerizing Biofeedback Workshops offered for experienced therapists. For brochure contact: The Professional School of Biofeedback Training; Southeast, 2429 University Blvd., W., Jacksonville, FL 32217. Or call (904) 737-5821.

MEDSTAFF is a multi-specialty locum tenes and permanent placement service. The most respected physician staffing group in the Southeast can provide you with coverage or work as our staff physician. Call: in the U.S. (800) 833-3465; NC (800) 672-5770; or write Medstaff, P.O. Box 15538, Durham, N.C. 27704.

Heart Healthy Recipe

BAKED BEANS

3 cups white beans (navy)
water
¾ cup chili sauce
1½ teaspoons vinegar
2 onions, sliced thinly
3 cups of bean juice
¾ teaspoon dry mustard
½ cup dark molasses

In a large pot, combine the dry beans and enough water to cover beans. Bring them to a boil, boil for 2 minutes then remove pot from heat. Let beans stand for 1 hour.

Combine the soaked beans with all above ingredients. The bean juice is the water in which the beans were soaking.

Put this mixture into an ovenproof crock, or casserole. Bake at 300°F. for 5 hours. Cover must be on all the time. If liquid evaporates, add more water.

Yield: 8 servings
Approx. cal/serv.: 160

Heart Healthy Recipes are from the Third Edition of the American Heart Association Cookbook. Copyright © 1973, 1975, 1979 by the American Heart Association, Inc.

American Heart Association
WE'RE FIGHTING FOR YOUR LIFE

A defense against cancer can be cooked up in your kitchen.



There is evidence that diet and cancer are related. Some foods may promote cancer, while others may protect you from it.



Foods related to lowering the risk of cancer of the larynx and esophagus all have high amounts of carotene, a form of Vitamin A which is in cantaloupes, peaches, broccoli, spinach, all dark green leafy vegetables, sweet potatoes, carrots, pumpkin, winter squash, and tomatoes, citrus fruits and brussels sprouts.

Foods that may help reduce the risk of gastrointestinal and respiratory tract cancer are cabbage, broccoli, brussels sprouts, kohlrabi, cauliflower.

Fruits, vegetables and whole-grain cereals such as oatmeal, bran and wheat may help lower the risk of colorectal cancer.



Foods high in fats, salt- or nitrite-cured foods such as ham, and fish and types of sausages smoked by traditional methods should be eaten in moderation.

Be moderate in consumption of alcohol also.

A good rule of thumb is cut down on fat and don't be fat. Weight reduction may lower cancer risk. Our 12-year study of nearly a million Americans uncovered high cancer risks particularly among people 40% or more overweight.



Now, more than ever, we know you can cook up your own defense against cancer. So eat healthy and be healthy.

No one faces cancer alone.

AMERICAN CANCER SOCIETY®

The Journal of the Florida Medical Association, Inc.

Classified Advertising Form

1. Please print or type all information requested and return this form to Ms. Sissy Crabtree, Managing Editor, *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203. **Deadlines for publication are the first of the month preceeding the month of publication.** *For example:* An ad to be run in October should be received by *The Journal* by September 1. **Classified advertising costs:** $10.00 for 25 words or less; then 25¢ for each word thereafter.

Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Signature _____ **Telephone** _____

2. Check here if you want your ad to run *continuously* until you cancel. If you want to specify only certain months, skip this and go to number 3. ☐

3. Check here to specify the months your ad should run. Place the last two digits of the year in the blanks.

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☐ May 19____ ☐ June 19____ ☐ July 19____ ☐ Aug. 19____
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4. Check here if you want ad responses sent to you via a Box number. This costs an additional $1. ☐

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☐ Check made payable to the FMA. Amount: $_____ ☐ Please bill me.

7. Use the lines below to print or type the ad *exactly* as it should appear. If necessary, additional paper may be used to complete ad.

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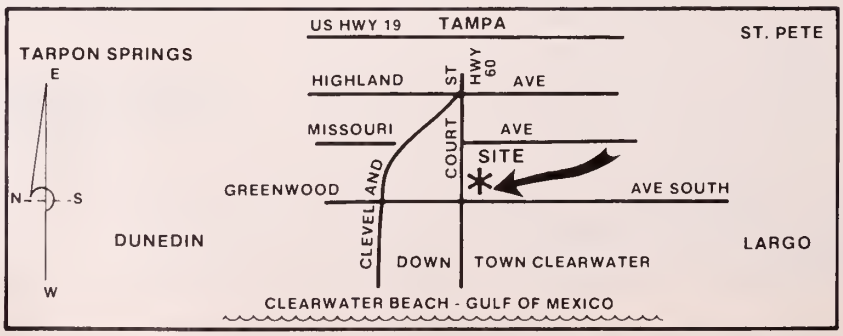
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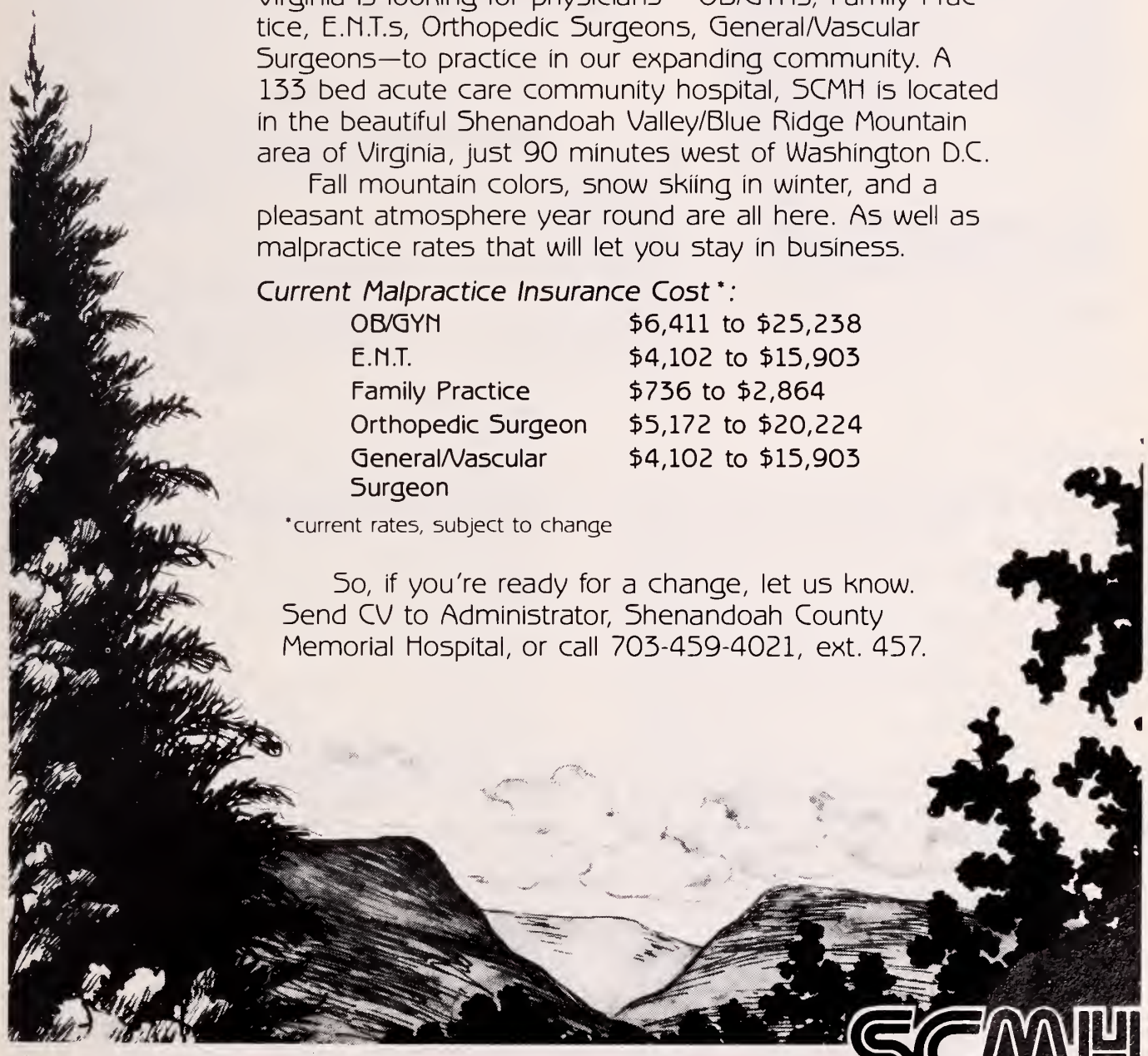
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References: 1. Flamenbaum W: *Am J Cardiol 57*(2):38A-43A, 1986. **2.** Brater DC, Fox WR, Chennavasin P: *J Clin Pharmacol 21*:599-603, 1981. **3.** Iber FL, Baum RA: *J Clin Pharmacol 21*:697-700, 1981. **4.** Henning R, Lundvall O: *Eur J Clin Pharmacol 6*:224-227, 1973. **5.** Physicians' Desk Reference, 40th ed. Oradell, NJ, Medical Economics Company, 1986, pp. 939, 1480. **6.** Pentikainen PJ, *et al*: *Br J Clin Pharmacol 4*:39-44, 1977. **7.** *Losix, A Review.* Somerville, NJ, Hoechst-Roussel Pharmaceuticals, Inc., 1980.

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Hyperuricemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion.
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Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions.
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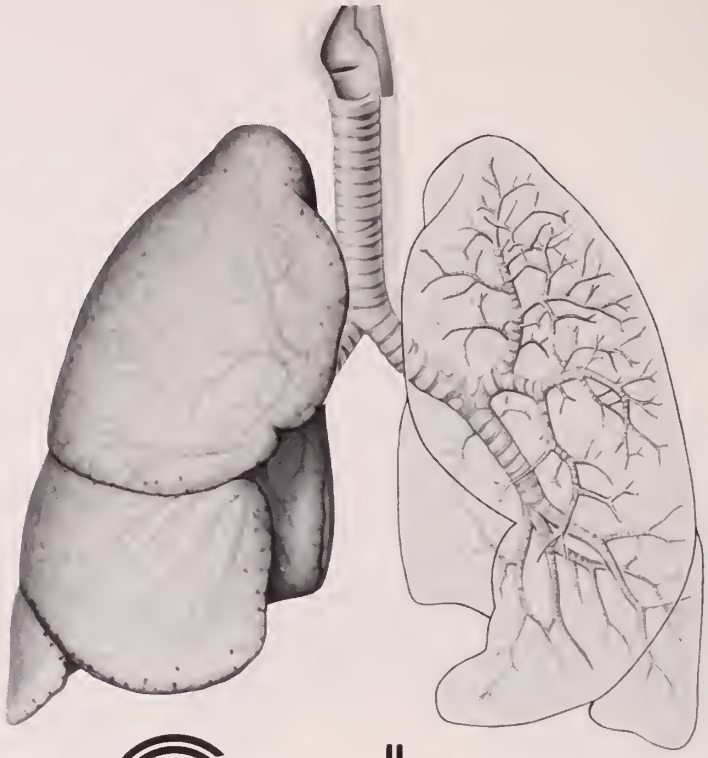
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Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

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SEPTEMBER 1987, Vol. 74, No. 9

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This month's cover of *The Journal* is a photograph by Anne B. Petty of Jacksonville depicting the spectacular fall foliage of North Carolina, the birthplace of the new FMA President, Dr. James G. White.

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A goodbye and some reflections



What is it that is bone-weary, a fairly happy person, and a reflective protagonist?

I suppose it is a past president of the Florida Medical Association. What should be said? I think, the word is: Bye!

Is there anything else to say? Yes, but I'm not sure anyone wants to read it or even less hear it. But, reflections? — Yes, there are many of them.

Perhaps as any neophyte tackling a challenge, goals and ideas are high, and they cause unrealistic and unattainable plans to be formulated. The result? When the world of reality doesn't agree or react in the fashion or with the rapidity that expectations demand, then frustration and anxiety occur.

The best laid plans of mice and men . . .

The year has been filled with excitement, however. There has been an awakening of Florida's physicians to the realism of pragmatic politics and dispelling of political naivete that so often comes from frustration and limited resources or knowledge.

All that is gone. We are now moving forward hopefully to realize a solution to the liability problems. Admittedly, this will take several years to filter out but the first steps are underway.

There has been the awakening of the conscience of Florida and the awareness of the need for care of all citizens. This has been transferred by purposeful legislation that is transmitted into dollars and commitment. The Florida Medical Association drafted a great deal of this and spurred a special issue of *The Journal* on indigent care which is a hallmark to be emulated by others in the future.

The Auxiliary has entered the mainstream of Florida's medicine, not as an "auxiliary," but as equal and important partners in the everyday decisions and actions in health care and issues of concern to all of the population.

With the problems that face medicine in the future we have taken a giant step. Addressing in a dynamic way the ethics of health care delivery and a more acute awareness of ourselves and our neighbor is the first step. We have this year, on several occasions, tackled this problem and a special edition of *The Journal* was dedicated to an indepth review of many problems affecting everyday life and the ethical considerations which orbit in a lattice work about each and every issue. This is important. It is especially necessary as we continue to face the multiple implications and problems of the AIDS epidemic. The ramifications of AIDS and the emotionalism and hysteria that accompany it are major obstacles to the true applications of science and technology that must be addressed in a rational way to solve the social problems emanating from the disease.

As for the future, new vistas in space exploration, travel and colonization will be a part of our everyday considerations probably before the turn of the century.

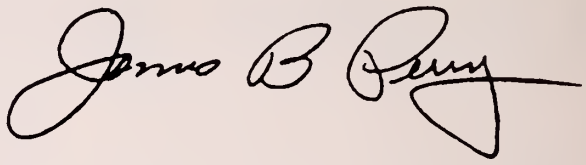
Concern and care for all people of all races and colors and of all nationalities and areas will be addressed on a daily basis by our successors who will continue to be The Florida Medical Association. There will be future policies, goals and ambitions as timely as those our predecessors have addressed for decades. All of us have a great heritage and a profound responsibility.

I wish to thank each and every member of the

Association for their support and good wishes. Special commendation for the entire staff, and also the Board of Governors is both desirable and offered without any constraint.

Congratulations to our new President Jim White and warm wishes to the new Board members, officers and committee members. Your time has come and your health and wisdom shall guide the Association to greater and more lofty ideas and goals as time passes.

Thank you for the opportunity to serve.





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This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

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In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
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Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

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Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

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Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
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The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
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Ulrich Sigwart, M.D.
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An ill wind blows across medicine

One of the primary obligations of medicine and other organized professions is to protect the public interest. The fulfillment of that obligation includes the right to speak up on matters affecting the practice of these professions, to examine pertinent issues, and even to criticize where this is appropriate. Free inquiry, after all, is as much the essence of our society as it is the catalyst for the advancement of science and of other learned pursuits. But an ill wind is blowing that may chill the inquiring mind.

A recent court decision in Chicago finding the AMA guilty of anti-trust violations for certain statements made against chiropractic is certain to renew the controversies surrounding chiropractic and perhaps to stir the public and enlightened politicians to acquaint themselves better with the issues. The complex legal issues in the case have been dissected in the courts and perhaps may be headed to a higher court for resolution. But just as fundamental an issue here is the right of medical physicians to speak out on chiropractic theory and practices and to ask questions in the light of current medical knowledge. If the chiropractic theory of disease as propounded by its founder, Daniel D. Palmer, is indeed unscientific, and if chiropractic practices derived from this theory are faulty, should that not vindicate the AMA for its criticisms of chiropractic? Should physicians be gagged by the court?

The answer to these questions cannot come from a judge or a jury; it can only come from the scientific community. Many physicians, as part of that community, have for many years expressed the view that the chiropractic theory of "subluxations" as causing human disease is unscientific, with no evidence to back it up. While manipulative therapy works for certain back problems, that is not to say that Palmer's theory is right. Unless evidence is forthcoming to vindicate Palmer, physicians should not feel compelled to shut up to serve the ends of economics at the price of putting a blindside to the cause of science.

The free flow of ideas is vital for the advancement of science, including medicine. The frontiers of science are open to both popular and unpopular ideas, some of which will be incorporated into our body of knowledge, while others will be discarded. The common requirement is that every theory, every idea, and every proposition should be subjected to the same rigid, exacting, and meticulous standards of the scientific method. The progress in medicine is wedded to this scientific tradition; advances in diagnosis, treatment, and basic sciences came from painstaking research involving countless manpower hours in laboratories across the nation. The good health and the prolonged longevity that most Americans now enjoy came about from those scientists working in the trenches, not from politicians, not from judges, and certainly not from penalizing the exercise of free speech.

The temporary court setback by the AMA should not lead the public to believe that physicians have unscrupulously banded together to denounce chiropractic purely for economic motives. That is far from the truth. Physicians criticize harshly their own profession. Dissent and adversarial exchanges of opinions have been going on vigorously in the medical community for many years. In addition, the tough peer review process in medicine respects nobody and assures the maintenance of high standards while diminishing the possibility of fraud and abuses. Fraud in science and medicine does occasionally happen but is almost always discovered, with the perpetrators certain to face harsh punishment. If physicians can be tough on their colleagues, why should it make any difference if they decide to express their opinions on

areas outside of their profession?

Even though chiropractic has been legitimatized politically in all states by legislative fiat, the public and the enlightened segment of our politicians must pursue vigorously the old question of its scientific legitimacy. Over 24,000 chiropractors are now practicing, offering various practices as an alternative to traditional medical care, and are now seeking hospital privileges. The potential impact on the health care of Americans and on the costs of this care is tremendous. Is it asking too much to require the chiropractors to explain the scientific foundation, if any, of their calling? Is it asking too much to require them to explain the scope of their practices and to justify them? Is it asking too much to set up peer review groups from knowledgeable people in the sciences to monitor what chiropractic care is all about? There are many more questions to be asked, but these are the questions that have been asked over and over through the years. The public is entitled to know the answers.

There is speculation that more chiropractors will now be emboldened to seek legislative help for hospital privileges. Let them try but physicians ought to be as vigilant as they have been in the past in thwarting any such attempt. Anybody who thinks that this is a question of money, of preserving the interests of one group over another, and of elbowing competition in medicine ought to have his back examined. It is a simple question of preserving the scientific integrity of medicine and of serving the public interest.

R. G. Lacsamana, M.D.
Editor

Looking at the Academic Task Force Report from different perspectives

I have recently read with interest several editorials in Florida newspapers in which the malpractice crisis and the preliminary findings of the Academic Task Force were discussed. In reading these editorials, it certainly appears there are several things on which most Floridians would agree. We would all agree that the malpractice crisis is a situation which must be resolved and resolved in a manner which leads victims able to collect what is due them and also leaves physicians in a position where they can purchase fairly priced malpractice insurance. Unfortunately, many of the editorials which I have been reading have been quoting the malpractice task force findings out of context. It appears that the legal profession and many of the editorials feel that the most equitable way to arrive at an answer to the problem would be a short range solution establishing a state-administered insurance pool for doctors and giving the state more power to discipline bad doctors. The proponents of this idea feel that spreading the cost of insurance among all physicians would be a fair way of attacking the problem. Inherent in all of these editorials is the fact that malpractice victims should be able to get compensated. This is something which I think all physicians and attorneys would agree on.

Many findings of the Task Force study have been cited, to support that this is an equitable and fair way to go. However, the Academic Task Force has said much more than most of the editorials have expounded. Granted, the report is very long, but there are some pertinent facts which I think everyone concerned with the malpractice insurance crisis should be made aware of. Some of the major findings not really emphasized in these editorials is that the cost of medical malpractice has increased drastically during the last eight years with the largest share of this increase coming during the last two years. The Academic Task Force found that the primary cause for the increased malpractice premiums has been a substantial increase in loss payments to claimants. It was also pointed out that during the past 30 years there has been a national trend toward expanded legal liability for medical malpractice and it appears that overall changes in the environment and legal system appear to benefit those who bring suit. Furthermore, the claimants have been receiving only 43 percent of the total incurred cost in any suit. Attorney fees and other litigation costs represent approximately 40 percent of the total incurred cost of insurance carriers. On the surface this does not appear to be an equitable system where the plaintiff who is rewarded damages gets only a little over 40 percent of the monies awarded by a verdict.

The Academic Task Force pointed out that 5 percent of the doctors are responsible for 50 percent of the claims. On the surface this seems to be a terrible judgement and implies that there are bad physicians who are wreaking havoc on the citizens of Florida. What is not said in this statistic is that those 5 percent of the doctors generally represent the high-risk categories such as the neurosurgeons and the obstetricians who handle disastrous cases every day. A neurosurgeon often has to operate on a victim of a gunshot wound to the head, a terrible spinal injury or the victim of an automobile accident and the results are often far from a return to normal. The number of neurosurgeons who have had suits filed against them in the state of Florida is approaching 90 percent. Does anyone think that 90 percent of the neurosurgeons in Florida are "bad doctors"? Of course not. It is just that this particular group of physicians, as well as other specialties, are often thrown into a situation where they cannot remake the person whom they are treating. If the problem were as simple as

removing the 5 percent of the physicians who have the majority of the cases brought against them, then we would effectively wipe out the neurosurgical care and the obstetrical care in the state of Florida.

Lastly, the idea of an insurance pool as being fair and equitable is far from that. Why is it fair for a primary doctor to have to pay more insurance so that the same system that pays only 40 percent of its claims to victims would prevail and which may not determine facts on the basis of right or wrong but often on the emotions of the juries? This is not an argument for juries to award less to true victims of malpractice, but it is an argument that many true victims of malpractice do not receive adequate compensation under the present system. On the other hand some plaintiffs with minor injuries receive excessively more than what is equitable and fair. Other states which have gone through the same crisis of the malpractice insurance have addressed it by looking at the tort system, removing malpractice from an adversarial and emotionally laden atmosphere and put it into a contract system in which emotions, personalities and other extemporaneous factors are removed.

Senator Barron has proposed such a plan in which malpractice is removed from the tort system, a system which has come to resemble a lottery. Damages awarded by juries may or may not fully and properly compensate the injured person, but regardless of this the attorney is still entitled to his contingency fee off the top of every award. Senator Barron has proposed a plan which is called the Medical Incident Compensation Act (MICA). Under this concept, an injured party must first prove that the health care provider practiced below the acceptable standard of care, which is the same test as in present law. However, under the MICA this decision will be made by a judge without a jury. If it is determined that this happened, then the claimant is entitled to specific damages based on economic loss. It would eliminate noneconomic losses, which sometimes run into the millions of dollars and is almost impossible to define. All of us would say that someone who has been damaged or has lost money because of an injury caused by negligence should certainly be entitled to all medical expenses and to all economic losses that have occurred as a result of that injury. The MICA plan would do this.

Under this plan, insurance coverage would be required of all providers so that those who have a legitimate claim will have the amount of monies available to them. It has been estimated by many economic experts that the overall cost would be reduced and therefore medical malpractice costs would be reduced. Incentives to take a case to court are drastically reduced because the "lottery syndrome" has been eliminated and if a case has limited merit in the first place, it would probably not be entered in the judicial system.

If the aim of any system is to make sure that those who have been hurt or injured improperly are to be compensated and to insure that there are enough of the various medical specialties to treat the injured person is of paramount importance, then this plan certainly should have no criticism.

It will probably have criticism from the Trial Attorneys' Bar because it will cut their fees in all probability and also will reduce the jumbo awards that are being given for noneconomic reasons. But is it fair to have multimillion dollars awarded for noneconomic reasons, of which the attorney gets 40 percent and the proliferation of this practice threatens to disrupt the medical care of this state?

Those attorneys and others who have taken excerpts of the preliminary report of the Academic Task Force and used it to bolster their position that the only thing wrong with the medical malpractice situation in the state of Florida is that we have bad doctors and are not policing them properly have either not read the report thoroughly and have not come to a grasp of what it is espousing, or are deliberately misrepresenting the facts. Granted, it is a lengthly report and it has to be studied in some detail to understand that this preliminary report of the Academic Task Force is not a blanket indictment of the medical profession, but points out some of the shortcomings of the tort system and is a reconfirmation of what physicians have been saying for many years.

It is hoped that all physicians will read the Academic Task Force so they can respond with factual data and rational thinking to those who attempt to misuse the findings to the detriment of the physicians and the medical care in this state.

H. Frank Farmer Jr., M.D., Ph.D.
New Smyrna Beach
Historical Editor

From all of us, prayers and wishes

A familiar face and one of the stalwart figures in Florida medicine has been conspicuously absent in recent FMA caucuses and meetings. Dr. Luis M. Perez, president of the FMA two years ago, suffered a stroke early this year and has been unable to pursue the one thing that he loves doing best: working for the interests of physicians and their patients. He has recovered quite slowly despite intensive physical therapy, and for his family, particularly his beloved wife and sidekick in all his professional and personal endeavors, Maria, the past few months when his health failed further have not been the best of times.

Louie, as he is known to his friends, could not at-

tend the recently concluded FMA meeting in Hollywood, the first time that he had missed an annual session in his many years of involvement with organized medicine. His colleagues all missed him with more than a twinge of sadness. In healthier times, he would have been there mixing it up with his friends, trading banter and cracking jokes, reciting the invocation, presiding over meetings, and charting the course of medicine in Florida. But Louie will be proud to know that the FMA is carrying on its job in the same distinguished tradition that he led it two years ago as the first Cuban-American physician to sit as the president. He will also be pleased to know that he has contributed a large part in the accomplishments of the FMA.

On behalf of his friends, colleagues, admirers, and employees of the FMA, we wish Dr. Perez good cheer and hope for more recovery from his present adversities; further, we pray for his burdens to be lighter and his days to be brighter.

Keep your spirits up, *amigo!*

R.G. Lacsamana, M.D.
Editor

To Georgia with love

The affable executive editor of *The Journal*, Dr. Robert C. Fore, is back to the land that he loves best: Georgia. Robert, his wife Rorie, and their children packed up their bags and said their good-byes to their friends at the FMA after he accepted an appointment as Assistant Dean for CME at Mercer School of Medicine and as Director for CME at the Medical Center of Central Georgia in Macon.

As Associate Executive Director for Programs and Administration at the FMA for the last five years, Robert worked behind the scenes quietly, diligently, and always efficiently. His boyish good looks and quiet dignity belie the many talents and skills that he brought to his job. As the point man for the FMA on continuing medical education (CME), he did a yeoman job, traveling extensively around the state, organizing meetings and seminars, surveying CME programs, and coordinating everything with the FMA Council on Scientific Activities. In his capacity as the executive editor of *The Journal*, he combined excellent managerial skills with a sharp editorial eye in guiding the day-to-day activities of the monthly publication. I know that my job as the editor of *The Journal* the past two and a half years has been a lot easier and much more pleasant because of Robert.

We wish Robert well and we know that he will do a splendid job just like he did with the FMA. He is moving on, he says, to enjoy the rainy nights, to cheer for his fighting Bulldawgs, but most of all to combine his interest in CME with his love for Georgia.

R. G. Lacsamana, M.D.
Editor

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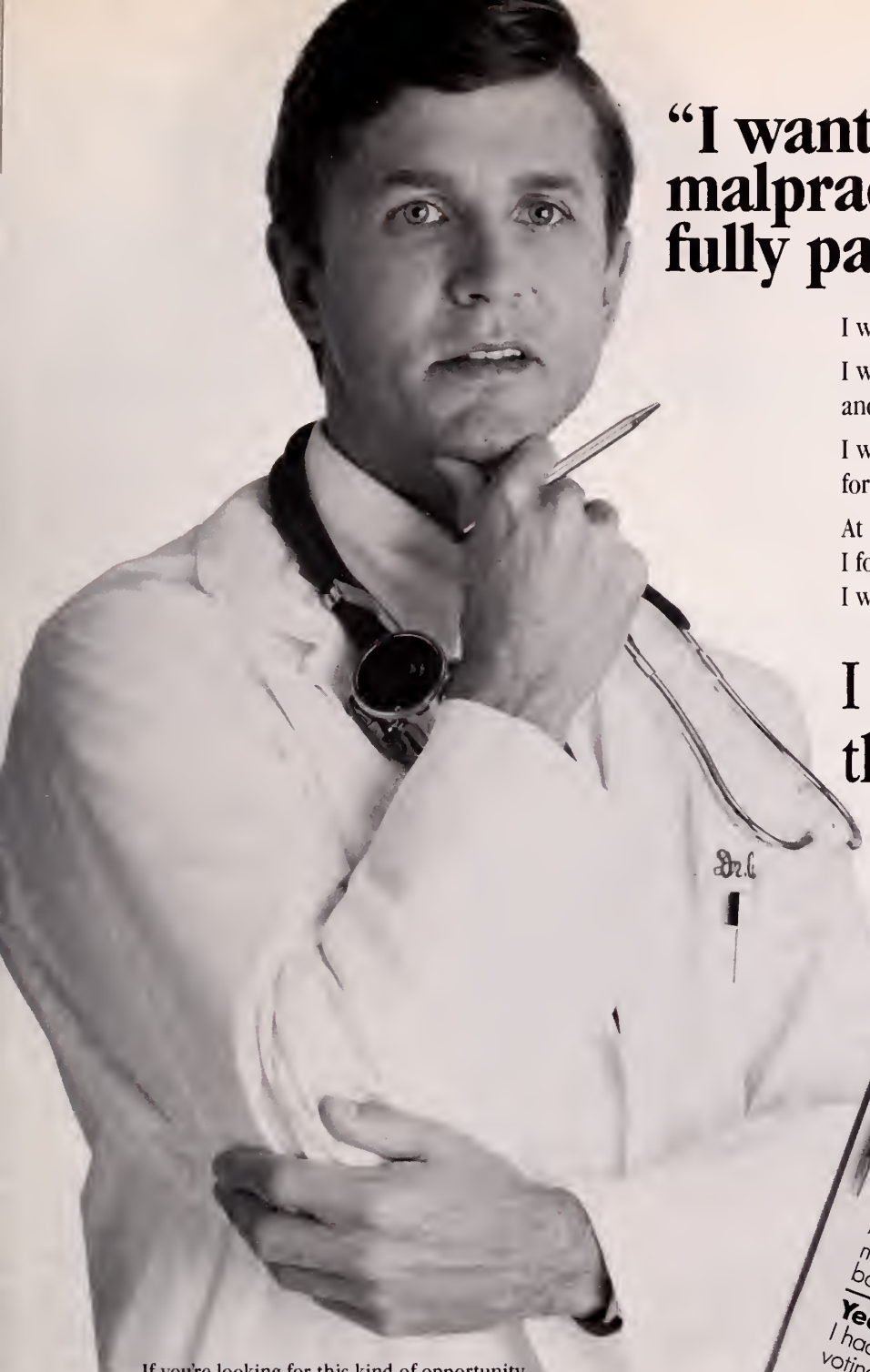
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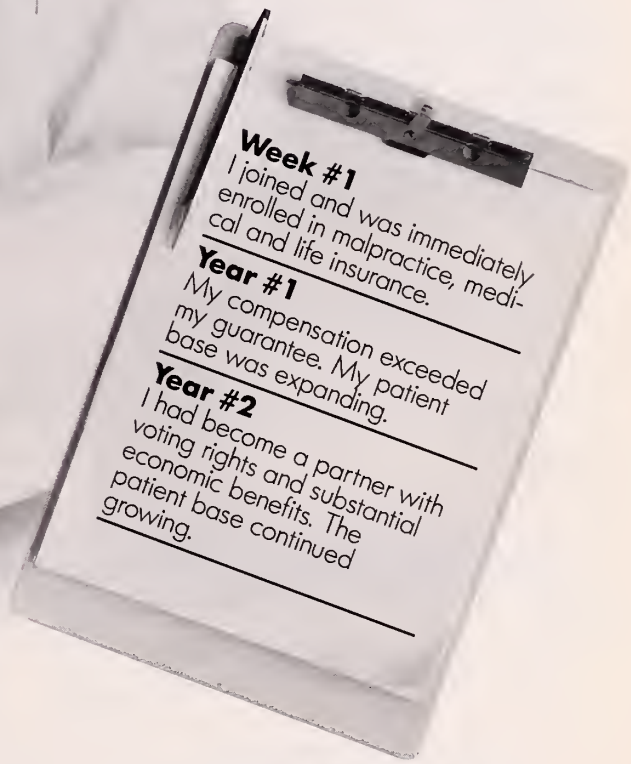
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Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:

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INFORMATION FOR AUTHORS

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Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should also be included.

References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. NO changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

Ulcer therapy that won't yield, even to smoking



What do you do for duodenal ulcer patients who should stop smoking, but won't? Both cimetidine[1] and ranitidine[2] have been shown less effective in smokers than nonsmokers.

Choose CARAFATE® (sucralfate/Marion). Two recent studies show Carafate to be as effective in smokers as nonsmokers.[3,4] A difference further illustrated in a 283-patient study comparing sucralfate to cimetidine[5]:

Ulcer healing rates:
(at four weeks of therapy)[5]

Sucralfate:	
All patients	79.4%
Smokers	81.6%*
Cimetidine:	
All patients	76.3%
Smokers	62.5%

*Significantly greater than cimetidine smoker group ($P<.05$).

Carafate has a unique, nonsystemic mode of action that enhances the body's own ulcer healing ability and protects the damaged mucosa from further injury.

When your ulcer patient is a smoker, prescribe the ulcer medication that won't go up in smoke: safe, nonsystemic Carafate.

Nothing works like

CARAFATE®
sucralfate/Marion

Please see adjoining page for references and brief summary of prescribing information.

1594H7

There's never been a better time for her..



and PREMARIN®



Proven benefits beyond relief of vasomotor symptoms

No other estrogen proven effective for osteoporosis

Only conjugated estrogens tablets have established efficacy in both osteoporosis[1] and vasomotor symptoms* at 0.625 mg/day. No other estrogen, oral or transdermal, has established clinical evidence or minimum effective dose in both indications.

No estrogen proven safer

PREMARIN is the most extensively tested estrogen, with an unsurpassed record of long-term safety.
And clinical evidence shows a significantly reduced risk of endometrial hyperplasia when cycled with a progestin.[2]

PREMARIN®
(conjugated estrogens tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms and for osteoporosis

PREMARIN®
(conjugated estrogens tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

The appearance of these tablets is a trademark of Ayerst Laboratories.

For atrophic vaginitis

PREMARIN®
(conjugated estrogens)

Vaginal Cream

0.625 mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nontiquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.
Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration. It therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP). Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen.

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, premenstrual-like syndrome, amenorrhea during and after treatment, increase in size of uterine fibromyomata, vaginal candidiasis, change in cervical erosion and in degree of cervical secretion, cystitis-like syndrome; tenderness, enlargement, secretion (of breasts), nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice, chloasma or melasma which may persist when drug is discontinued, erythema multiforme; erythema nodosum, hemorrhagic eruption, loss of scalp hair, hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea, increase or decrease in weight, reduced carbohydrate tolerance, aggravation of porphyria, edema, changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause: (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Osteoporosis. Female castration. Osteoporosis.—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae:

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Lindsay R, Hart DM, Clark DM: The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. **2.** Studd JWW, Thom MH, Paterson MEL, et al: The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrus JL (eds): *The Menopause and Postmenopause*. Lancaster, England, MTP Press Ltd, 1980, chap 13.

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New York, NY 10017

The malpractice crisis and bad doctors

In the wake of this summer's medical malpractice crisis, I have seen references in newspapers and on television linking the problem to "bad doctors." In support of this, the Government Accounting Office report has been cited (and misinterpreted) which stated about 50% of money paid out for malpractice claims arose from only 4% of Florida's doctors. This supposedly means that four percent of the State's doctors are responsible for about one-half the malpractice suits! What this statistic means is simply this. In a period of time studied, a relatively small number of multi-million dollar judgements against a few physicians comprise about 50% of the money paid out in that period. In any subsequent period, there would again be a small number of doctors which would be hit with large judgements. But the doctors who lost cases in each period would not be the same ones. Paul Sharpe, Vice President of St. Paul Insurance Company, has said that his company has not been able to identify a small group of doctors who repeatedly lose malpractice cases. If this were so, they would solve their problem easily by no longer writing insurance for that group of doctors.

Moreover, the above GAO statistics completely ignore the majority of claims filed against Florida's physicians. Most suits filed do not result in any damages being paid. Yet these litigations exact a heavy toll. Defense attorneys and expert witnesses must be paid, the physician spends time and energy away from his practice, and he suffers psychological and emotional distress. What editorial writers, reporters, and politicians apparently do not know is that the dedicated physician in a high risk specialty is the most likely sued. This is the physician whose task is to treat premature infants who often, in spite of the best care in the world, will be disabled and mentally retarded. This is the physician who treats sick folks who lose a limb, suffer a stroke, die or wither away on a respirator. This is the physician who still responds to emergencies, treating people who have been shot, stabbed, or mangled in an automobile accident — who end up paralyzed, brain damaged, or in a vegetative state. This then becomes a fertile ground where malpractice suits are born and grow.

In my seven-year experience as a neurosurgeon at a large, urban hospital in Broward County, six malpractice lawsuits have been filed against me. No matter how confident I feel that I am a well-trained, competent physician, these repeated assaults leave my ego somewhat battered and scarred. I need to remind myself that all that's required for a doctor to be sued is for him to treat a patient. All the rest can be done by others.

Need I say the foregoing does not imply that all physicians practice good medicine. We have a serious problem of bad doctors and bad medicine. Although I hear pious talk about cracking down on bad doctors, I haven't heard how this is to be done. Obviously, to achieve this, one must first identify what is bad medicine and who is practicing bad medicine. I can list three kinds of practitioners who I would call bad doctors. The incompetent physician, whether by failure in training, failure to maintain excellency in an advancing field, or from a character flaw, is a threat to his patient. The quack or charlatan skillfully peddles the latest fad, and not only gouges the unsuspecting patient but also may injure by delaying the proper diagnosis. Then there is the practitioner I call the opportunist. His deviation from the standard of care is subtle. His care centers on obtaining a myriad of expensive and sophisticated tests. The patient may be flattered his physician is sparing no costs to diagnose his illness, not knowing all are done simply for profit. Now aided by newfangled diagnostic equipment,

the possibilities are nearly unlimited. Patients are referred by personal injury lawyers with whom he maintains a symbiotic relationship.

But after having identified the undesirable practitioner, our task has just begun. How do we make him change how he practices medicine, or force him to quit? He will meet you at every step with his attorney. Isn't it ironic that the same lawyers who profess altruistic motives in suing doctors will now be helping the practitioner who is truly a burden to society? Discipline must come from an officially recognized body or panel at the state level. Peer discipline at the local hospital staff level is sporadic, and is often motivated by economic and political factors.

Facing medicine today are two problems — malpractice and bad doctors — each exists independently and must be solved separately. To say one problem is caused by the other is not only blatantly false, but also fails to contribute to the solution of either one.

Amos Stoll, M.D.
Ft. Lauderdale

No malpractice problem in Canada and England

Why is it that there is no malpractice crisis in Canada and England?

Until 12 years ago, I paid $75.00 for professional liability for $100,000 and $300,000 coverage.

Why is it that until several years ago an obstetrician in Windsor, Canada paid $50.00 for professional liability while an obstetrician in Detroit paid $35,000 to $40,000?

There is only one answer. The contingency fee practice is illegal in Canada and England. In addition, there are twice the number of attorneys needed in Florida.

Enough said.

J. C. Weisman, M.D.
Maitland

Response to Gov. Lamm's article

Richard Lamm, former Governor of Colorado, made some valid points in his eight-count indictment of America's health care system. In truth, however, most of those indictments should be directed at American society. By and large, the health care industry is simply doing what Americans want.

We can all agree that "America could be healthier if we concentrated efforts on cutting the use of tobacco and alcohol, on improving our diets and using seat belts . . . " The problem is that most Americans want to be able to eat, smoke and/or drink to excess for most of their lives. When their lives become severely threatened by those excesses (which are largely liable for our major killing diseases,) they expect to be rescued by the health care team of America.

Obviously, this is an extremely expensive way to run the system. From any logical standpoint it is sheer madness to finance this kind of plan. Yet that is precisely what America's insurance and political systems have done with our present insurance and Medicare structures. Peer review mechanisms can not and will not alter these underlying structures.

Only when all Americans wholeheartedly adopt 'wellness' as a way of life will there be some hope of basic change in health care structures. Only when our society adopts a more wholesome attitude towards death will we be able to stop the hemorrhage of enormous resources to stave off death for the last six months of life. That day will come when the average citizen establishes a living will which says in effect, "I have lived a good life. Let me go in peace," and when the average family gracefully accepts this kind of decision.

The 'wellness way of life' and the 'peaceful acceptance of death' are foundational themes which are accepted now by a small minority of Americans. Acceptance by most Americans will require major adjustment in outlook. Clearly, all segments of society including health, religious, legal, political and educational sectors must exert leadership for society to cope successfully with such change. Until that day comes, it does not seem useful or right to blame America's health care team for doing the rescue work society asks it to do.

R. Edward Dodge, M.D.
Inverness

Mean,

Powerful against susceptible pathogens.*

lean &

Easy on tight budgets.

clean.

Gentle to patients (generally well tolerated).

The one antimicrobial that
belongs on every formulary.

Once-a-day

Rocephin® ROCHE IV·IM

ceftriaxone sodium/Roche

* ROCEPHIN is indicated in the following infections: bacterial septicemia, bone and joint, intra-abdominal, lower respiratory tract, skin and skin structure, urinary tract, bacterial meningitis and gonorrhea. Please see summary of product information on adjacent page for indicated susceptible organisms.

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Please see adjacent page for summary of product information.

Rocephin® IV·IM

ceftriaxone sodium/Roche

Before prescribing, please consult complete product information, a summary of which follows:

MICROBIOLOGY The bactericidal activity of ceftriaxone results from inhibition of cell wall synthesis. Ceftriaxone has a high degree of stability in the presence of beta-lactamases, both penicillinases and cephalosporinases, of gram-negative and gram-positive bacteria. Ceftriaxone is usually active against the following microorganisms *in vitro* and in clinical infections (see Indications and Usage):

GRAM-NEGATIVE AEROBES: *Enterobacter aerogenes, Enterobacter cloacae, Escherichia coli, Haemophilus influenzae* (including ampicillin-resistant strains), *H parainfluenzae, Klebsiella* species (including *K. pneumoniae*), *Neisseria gonorrhoeae* (including penicillinase and nonpenicillinase producing strains), *Neisseria meningitidis, Proteus mirabilis, Proteus vulgaris, Morganella morganii* and *Serratia marcescens*.

Note: Many strains of the above organisms that are multiply resistant to other antibiotics, e.g., penicillins, cephalosporins and aminoglycosides, are susceptible to ceftriaxone sodium.

Ceftriaxone is also active against many strains of *Pseudomonas aeruginosa*.

GRAM-POSITIVE AEROBES: *Staphylococcus aureus* (including penicillinase-producing strains) and *Staphylococcus epidermidis* (Note: methicillin-resistant staphylococci are resistant to cephalosporins, including ceftriaxone), *Streptococcus pyogenes* (Group A beta-hemolytic streptococci), *Streptococcus agalactiae* (Group B streptococci) and *Streptococcus pneumoniae* (Note: Most strains of enterococci, *Streptococcus faecalis* and Group D streptococci are resistant.)

Ceftriaxone also demonstrates *in vitro* activity against the following microorganisms, although the clinical significance is unknown.

GRAM-NEGATIVE AEROBES: *Citrobacter freundii, Citrobacter diversus, Providencia* species (including *Providencia rettgeri*), *Salmonella* species (including *S. typhi*), *Shigella* species and *Acinetobacter calcoaceticus*.

ANAEROBES: *Bacteroides* species, *Clostridium* species (Note: most strains of *C difficile* are resistant).

SUSCEPTIBILITY TESTING: Standard susceptibility disk method. Quantitative methods that require measurement of zone diameters give the most precise estimate of antibiotic susceptibility. One such procedure (Bauer AW, Kirby WMM, Sherris JC, Turck M: Antibiotic Susceptibility Testing by a Standardized Single Disk Method, *Am J Clin Pathol* 45: 493-496, 1966; Standardized Disk Susceptibility Test, *Federal Register* 39: 19182-19184, 1974, National Committee for Clinical Laboratory Standards, Approved Standard ASM 2, Performance Standards for Antimicrobial Disk Susceptibility Tests, July 1975.) has been recommended for use with disks to test susceptibility to ceftriaxone.

Laboratory results of the standardized single-disk susceptibility test using a 30-mcg ceftriaxone disk should be interpreted according to the following three criteria:

1. Susceptible organisms produce zones of 18 mm or greater, indicating that the tested organism is likely to respond to therapy.
2. Organisms that produce zones of 14 to 17 mm are expected to be susceptible if a high dosage (not to exceed 4 gm per day) is used or if the infection is confined to tissues and fluids (e.g., urine), in which high antibiotic levels are attained.
3. Resistant organisms produce zones of 13 mm or less, indicating that other therapy should be selected.

Organisms should be tested with the ceftriaxone disk, since ceftriaxone has been shown by *in vitro* tests to be active against certain strains found resistant to cephalosporin class disks.

Organisms having zones of less than 18 mm around the cephalothin disk are not necessarily of intermediate susceptibility or resistant to ceftriaxone.

Standardized procedures require use of control organisms. The 30-mcg ceftriaxone disk should give zone diameters between 29 and 35 mm, 22 and 28 mm and 17 and 23 mm for the reference strains *E coli* ATCC 25922, *S aureus* ATCC 25923 and *P aeruginosa* ATCC 27853, respectively.

DILUTION TECHNIQUES: Based on the pharmacokinetic profile of ceftriaxone, a bacterial isolate may be considered susceptible if the MIC value for ceftriaxone is not more than 16 mcg/ml. Organisms are considered resistant to ceftriaxone if the MIC is equal to or greater than 64 mcg/ml. Organisms having an MIC value of less than 64 mcg/ml, but greater than 16 mcg/ml, are expected to be susceptible if a high dosage (not to exceed 4 gm per day) is used or if the infection is confined to tissues and fluids (e.g., urine), in which high antibiotic levels are attained.

E coli ATCC 25922, *S aureus* ATCC 25923 and *P aeruginosa* ATCC 27853 are also the recommended reference strains for controlling ceftriaxone dilution tests. Greater than 95% of MICs for the *E coli* strain should fall within the range of 0.016 to 0.5 mcg/ml. The range for the *S aureus* strain should be 1 to 2 mcg/ml, while for the *P aeruginosa* strain the range should be 8 to 64 mcg/ml.

INDICATIONS AND USAGE: Rocephin is indicated for the treatment of the following infections when caused by susceptible organisms:

LOWER RESPIRATORY TRACT INFECTIONS caused by *Strep pneumoniae, Streptococcus* species (excluding enterococci), *Staph aureus, H influenzae, H parainfluenzae, Klebsiella* species (including *K. pneumoniae*), *E coli, E aerogenes, Proteus mirabilis* and *Serratia marcescens*.

SKIN AND SKIN STRUCTURE INFECTIONS caused by *Staph aureus, Staph epidermidis, Streptococcus* species (excluding enterococci), *E cloacae, Klebsiella* species (including *K. pneumoniae*), *Proteus mirabilis* and *Pseudomonas aeruginosa*.

URINARY TRACT INFECTIONS (complicated and uncomplicated) caused by *E coli, Proteus mirabilis, Proteus vulgaris, M morganii* and *Klebsiella* species (including *K pneumoniae*).

UNCOMPLICATED GONORRHEA (cervical/urethral and rectal) caused by *Neisseria gonorrhoeae*, including both penicillinase and nonpenicillinase producing strains.

PELVIC INFLAMMATORY DISEASE caused by *N gonorrhoeae*.

BACTERIAL SEPTICEMIA caused by *Staph aureus, Strep pneumoniae, E coli, H influenzae* and *K pneumoniae*.

BONE AND JOINT INFECTIONS caused by *Staph aureus, Strep pneumoniae, Streptococcus* species (excluding enterococci), *E coli, P mirabilis, K pneumoniae* and *Enterobacter* species.

INTRA-ABDOMINAL INFECTIONS caused by *E coli* and *K pneumoniae*.

MENINGITIS caused by *H influenzae, N meningitidis* and *Strep pneumoniae*. Ceftriaxone has also been used successfully in a limited number of cases of meningitis and shunt infections caused by *Staph epidermidis* and *E coli*.

PROPHYLAXIS: The administration of a single dose of ceftriaxone preoperatively may reduce the incidence of postoperative infections in patients undergoing coronary artery bypass surgery.

Although ceftriaxone has been shown to have been as effective as cefazolin in the prevention of infection following coronary artery bypass surgery, no placebo-controlled trials have been conducted to evaluate any cephalosporin antibiotic in the prevention of infection following coronary artery bypass surgery.

SUSCEPTIBILITY TESTING: Before instituting treatment with Rocephin, appropriate specimens should be obtained for isolation of the causative organism and for determination of its susceptibility to the drug. Therapy may be instituted prior to obtaining results of susceptibility testing.

CONTRAINDICATIONS: Rocephin is contraindicated in patients with known allergy to the cephalosporin class of antibiotics.

WARNINGS: BEFORE THERAPY WITH ROCEPHIN IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS, PENICILLINS, OR OTHER DRUGS. THIS PRODUCT SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. ANTIBIOTICS SHOULD BE ADMINISTERED WITH CAUTION TO ANY PATIENT WHO HAS DEMONSTRATED SOME FORM OF ALLERGY, PARTICULARLY TO DRUGS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE THE USE OF SUBCUTANEOUS EPINEPHRINE AND OTHER EMERGENCY MEASURES.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad-spectrum antibiotics), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.

ROCEPHIN® (ceftriaxone sodium/Roche)

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind to the toxin *in vitro*.

Mild cases of colitis respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated.

When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: *GENERAL*: Although transient elevations of BUN and serum creatinine have been observed, at the recommended dosages, the nephrotoxic potential of Rocephin is similar to that of other cephalosporins.

Ceftriaxone is excreted via both biliary and renal excretion (see Clinical Pharmacology). Therefore, patients with renal failure normally require no adjustment in dosage when usual doses of Rocephin are administered, but concentrations of drug in the serum should be monitored periodically. If evidence of accumulation exists, dosage should be decreased accordingly.

Dosage adjustments should not be necessary in patients with hepatic dysfunction, however, in patients with both hepatic dysfunction and significant renal disease, Rocephin dosage should not exceed 2 gm daily without close monitoring of serum concentrations.

Alterations in prothrombin times have occurred rarely in patients treated with Rocephin. Patients with impaired vitamin K synthesis or low vitamin K stores (e.g., chronic hepatic disease and malnutrition) may require monitoring of prothrombin time during Rocephin treatment. Vitamin K administration (10 mg weekly) may be necessary if the prothrombin time is prolonged before or during therapy.

Prolonged use of Rocephin may result in overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Rocephin should be prescribed with caution in individuals with a history of gastrointestinal disease, especially colitis.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Carcinogenesis: Considering the maximum duration of treatment and the class of the compound, carcinogenicity studies with ceftriaxone in animals have not been performed. The maximum duration of animal toxicity studies was six months.

Mutagenesis: Genetic toxicology tests included the Ames test, a micronucleus test and a test for chromosomal aberrations in human lymphocytes cultured *in vitro* with ceftriaxone. Ceftriaxone showed no potential for mutagenic activity in these studies.

Impairment of Fertility: Ceftriaxone produced no impairment of fertility when given intravenously to rats at daily doses up to 586 mg/kg/day, approximately 20 times the recommended clinical dose of 2 gm/day.

PREGNANCY: Teratogenic Effects: Pregnancy Category B: Reproductive studies have been performed in mice and rats at doses up to 20 times the usual human dose and have no evidence of embryotoxicity, fetotoxicity or teratogenicity. In primates, no embryotoxicity or teratogenicity was demonstrated at a dose approximately three times the human dose.

There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproductive studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nonteratogenic Effects: In rats, in the Segment I (fertility and general reproduction) and Segment III (perinatal and postnatal) studies with intravenously administered ceftriaxone, no adverse effects were noted on various reproductive parameters during gestation and lactation, including postnatal growth, functional behavior and reproductive ability of the offspring, at doses of 586 mg/kg/day or less.

NURSING MOTHERS: Low concentrations of ceftriaxone are excreted in human milk. Caution should be exercised when Rocephin is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness of Rocephin in neonates, infants and children have been established for the dosages described in the Dosage and Administration section.

ADVERSE REACTIONS: Rocephin is generally well tolerated. In clinical trials, the following adverse reactions, which were considered to be related to Rocephin therapy or of uncertain etiology, were observed:

LOCAL REACTIONS—pain, induration or tenderness at the site of injection (1%). Less frequently reported (less than 1%) was phlebitis after I.V. administration.

HYPERSENSITIVITY—rash (1.7%). Less frequently reported (less than 1%) were pruritus, fever or chills.

HEMATOLOGIC—eosinophilia (6%), thrombocytosis (5.1%) and leukopenia (2.1%). Less frequently reported (less than 1%) were anemia, neutropenia, lymphopenia, thrombocytopenia and prolongation of the prothrombin time.

GASTROINTESTINAL—diarrhea (2.7%). Less frequently reported (less than 1%) were nausea or vomiting, and dysgeusia.

HEPATIC—elevations of SGOT (3.1%) or SGPT (3.3%). Less frequently reported (less than 1%) were elevations of alkaline phosphatase and bilirubin.

RENAL—elevations of the BUN (1.2%). Less frequently reported (less than 1%) were elevations of creatinine and the presence of casts in the urine.

CENTRAL NERVOUS SYSTEM—headache or dizziness were reported occasionally (less than 1%).

GENITOURINARY—moniliasis or vaginitis were reported occasionally (less than 1%).

MISCELLANEOUS—diaphoresis and flushing were reported occasionally (less than 1%).

Other rarely observed adverse reactions (less than 0.1%) include leukocytosis, lymphocytosis, monocytosis, basophilia, a decrease in the prothrombin time, jaundice, glycosuria, hematuria, bronchospasm, serum sickness, abdominal pain, colitis, flatulence, dyspepsia, palpitations and epistaxis.

DOSAGE AND ADMINISTRATION: Rocephin may be administered intravenously or intramuscularly. The usual adult daily dose is 1 to 2 gm given once a day (or in equally divided doses twice a day) depending on the type and severity of the infection. The total daily dose should not exceed 4 grams.

For the treatment of serious miscellaneous infections in children, other than meningitis, the recommended total daily dose is 50 to 75 mg/kg (not to exceed 2 grams), given in divided doses every 12 hours.

Generally, Rocephin therapy should be continued for at least two days after the signs and symptoms of infection have disappeared. The usual duration is 4 to 14 days, in complicated infections longer therapy may be required.

In the treatment of meningitis, a daily dose of 100 mg/kg (not to exceed 4 grams), given in divided doses every 12 hours, should be administered with or without a loading dose of 75 mg/kg.

For the treatment of uncomplicated gonococcal infections, a single intramuscular dose of 250 mg is recommended.

For preoperative use (surgical prophylaxis), a single dose of 1 gm administered ½ to 2 hours before surgery is recommended.

When treating infections caused by *Streptococcus pyogenes*, therapy should be continued for at least ten days.

No dosage adjustment is necessary for patients with impairment of renal or hepatic function, however, blood levels should be monitored in patients with severe renal impairment (e.g., dialysis patients) and in patients with both renal and hepatic dysfunctions.

HOW SUPPLIED: Rocephin (ceftriaxone sodium/Roche) is supplied as a sterile crystalline powder in glass vials and piggyback bottles. The following packages are available:

Vials containing 250 mg equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1962-01)

Vials containing 500 mg equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1963-01)

Vials containing 1 gm equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1964-01)

Piggyback bottles containing 1 gm equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1964-03)

Vials containing 2 gm equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1965-01)

Piggyback bottles containing 2 gm equivalent of ceftriaxone. Boxes of 10 (NDC 0004-1965-03)

Bulk pharmacy containers, containing 10 gm equivalent of ceftriaxone. Boxes of 1 (NDC 0004-1971-01)

NOT FOR DIRECT ADMINISTRATION.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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AIDS: Legal issue spotting for the health care practitioner

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ABSTRACT: This article deals with the identification of certain legal problems, prompted by the discovery of AIDS or positive HIV test results, that may be encountered at any time, by any health care practitioner. The subject matter may be grouped under three headings: Patient care; health care practitioner's workplace, and social/political matters.

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During the 1980s recognition of the acquired immunodeficiency syndrome (AIDS) and discovery of the human immunodeficiency virus (HIV), the retrovirus considered pathogenic for transmission of AIDS, have caused an explosion in many areas of medicine including basic science research, clinical research, diagnostic evaluations, treatment decisions, and medical ethics. There are many legal issues which are by-products of the scientific developments associated with AIDS. The legal implications of interacting with patients or co-workers who are infected with HIV should be considered by all health care practitioners. While an expansive discussion of these matters would cover several hundreds of pages, it is useful to delineate several legal issues relating to AIDS and HIV infection which may be pertinent for health care providers. The problems may be grouped under three headings: patient care, health care practitioner's workplace, and sociopolitical matters. This discussion uncovers some of the questions prompted by the discovery of AIDS.

Patient Care • A physician must be informed about HIV infection and AIDS and must examine and counsel his/her patients according to current clinical knowledge. A physician has a duty to educate him/herself about the epidemiology of HIV and the clinical pattern of development of symptomatic sequelae of HIV infection including AIDS. A physician must take an adequate social history from patients in order to identify those whose lifestyles put them at risk for infection with HIV, pose a danger for infecting others with HIV, or (among those infected with HIV) are associated with the development of AIDS. Physicians should counsel such patients about the risks engendered by their lifestyles. Practitioners who are uncomfortable discussing intimate matters should

refer patients to providers who are knowledgeable about HIV and who can discuss such issues with composure. In addition, physicians should educate members of their communities regarding the relative degrees of risk involved with different lifestyle choices and ways to reduce risk through prudent behaviors.[1]

Testing for the presence of HIV antibody introduces several concerns for those who provide health care to patients in jeopardy for developing AIDS. A physician must identify those at risk, determine who might benefit from testing, and counsel patients accordingly. A physician might be found at fault for failing to suggest that a patient, known to be a member of a high risk group, be tested for HIV. This failure to diagnose HIV infection could result in harm to a patient who might delay undergoing appropriate treatments for this condition (as may become available generally or on an experimental basis), or may cause injury to a third party who becomes infected with the virus from intimate contact with or parenteral exposure to bodily fluids from the undiagnosed patient. Failure to test for HIV in a pregnant female (or even any female with reproductive potential) who is at risk for HIV positivity may chance a claim by a neonate who becomes infected transplacentally.

When testing for HIV is appropriate, a physician should discuss with his/her patient the meanings of positive and negative results and should warn about possible disclosure of (positive) test results as may be required by law. One should note the potential for disclosure of positive HIV serology to intimate contacts. A doctor should obtain informed consent for taking the test. Failure to obtain informed consent could risk an action for battery.

For those who test positive for HIV, a physician has a duty to explain the clinical importance and prognosis of this finding according to currently available information. He/she should suggest a diet and exercise plan which may be helpful to decrease the risk for developing symptomatic disease (AIDS or other conditions associated with HIV infection), and must counsel regarding prompt follow-up should symptoms or signs of serious complications ensue. A doctor is obliged to consider the psychological impact of a positive test for HIV antibody including the potential for suicide. In addition, a physician should counsel his/her patient about behaviors which are prudent to avoid infecting others.[2]

Failure to warn a patient about his/her infectivity may hazard a claim by a third party for causing the third party to become infected by the patient. In addition, doctors may be under a duty to warn certain third parties, e.g., known intimate contacts, of the risk. Conversely, a doctor may be liable for a claim of breach of privacy for disclosing confidential information which may cause serious restrictions on a patient's liberty. Physicians must consider the potential consequences of disclosure of either HIV positive status or a patient's underlying lifestyle choices which may have placed him/her at risk for HIV, e.g., discrimination in housing, employment, insurability, obtaining services from welfare agencies.[3]

In the hospital setting additional questions are sparked regarding access to and use of HIV test results by insurers, worker's compensation agencies, or prepaid plans which are paying for the hospitalization. Additional considerations include the format for reporting test results in the medical record, e.g., whether a positive test result should be included in a problem list or discharge summary or whether a patient's request for using coded samples without recording test results may be honored.[4] A physician's liability for negligent breach of confidentiality by the clinical laboratory through unauthorized disclosure of results is another concern for the practitioner. A doctor may also chance a claim by a patient for failing to warn adequately of contagion thereby exposing him/her to civil and/or criminal liability for infecting others or exposing others to a risk of infection.[5]

Insofar as a physician fails to inform his/her patient of the potential for infecting others, it would be unlikely that such patient would be found at fault for having infected another. This would decrease the physician's liability to the patient in this regard but likely would increase the chance for the physician's being found culpable to a third party infected by this patient. In addition, physician records containing data about HIV serology or AIDS may be requested in connection with civil or criminal litigation relating to a third party's becoming infected by a patient. Conflicts between physician-patient confidentiality and compulsory process may result. These questions may be resolved inconsistently by courts leaving physicians without clear guidance concerning how to counsel their patients about the potential for disclosure of test results.[6]

A physician's decision whether or not to treat AIDS or HIV positive patients sparks important ethical and legal questions. There are reports of health care workers who are reluctant to treat AIDS patients.[7] Several authorities have advised that discrimination against AIDS patients is unethical.[8] While physicians may not be required to treat AIDS patients, state and federal laws prohibiting discrimination against handicapped persons may be involved. First, practitioners in state supported institutions who refuse to treat HIV positive or AIDS patients may violate state antidiscrimination laws.[9] Second, physicians treating patients under reimbursement from Medicare or Medicaid are subject to federal laws proscribing discrimination against handicapped persons.[10]

Physicians must be able to diagnose accurately the sequelae of infection with HIV including persistent generalized lymphadenopathy, constitutional symptoms, neurological disease, and secondary infectious or neoplastic diseases.[11]Physicians must remain reasonably up to date regarding diagnostic and

therapeutic options and should inform their patients of appropriate treatments on a continuing basis. Doctors should invite patients to enroll in research protocols as these may be available and suitable. Practitioners may need to obtain informed consent for these studies if they are administered through the physician's office. In addition, a physician should inform his/her patient about the long-term prognosis of his/her disease and should discuss the patient's desires regarding the use of life-prolonging measures should such be required in the future. Many states now accord expressed wishes made by competent adults regarding the use of life-prolonging medical treatments. Statutory and common law schemes vary among states concerning the type of procedures which are considered life-prolonging measures, e.g., whether alimentation or fluids are included, the requirement that the illness be terminal before life-prolonging measures may be discontinued, and the nature of the proceeding required for terminating life-prolonging measures, e.g. self-executing "living will", judicial procedure involving appointment of a guardian, or "substituted judgment" by the court.[12]

Health care practitioner's workplace ● Health care providers caring for HIV carriers, those who have employees who are HIV positive, and physicians who themselves may have been exposed to HIV must consider the risks such HIV positivity introduces to employees, to others who enter the provider's workplace, and to (non-exposed) physicians themselves. Practitioners have a duty to their employees to disclose risks of harm present at the workplace and to make the workplace reasonably safe. In addition, collective bargaining agreements or other employee contracts may contain provisions relating to the safety of the workplace. Employees who become infected with HIV due to exposure at work would have a claim for worker's compensation. Furthermore, employees who are exposed to HIV, e.g. needlestick from an HIV positive source, but who do not become infected may file claims for stress-related diseases arguing that such illness occurred because of anxiety due to HIV exposure at work. Employees may try filing claims outside the worker's compensation system for negligent failure to disclose harmful conditions at the workplace or failure to use due care in keeping the workplace safe.[13]

Patients, trash-handlers, and delivery persons who transport blood samples may have claims against a health care provider for failure to warn or take due care to make the workplace (or articles transported therefrom) safe for those invited into the workplace. While these actions likely would be based upon negligence, strict liability under an ultrahazardous activity theory or breach of contract (to use due care in making the workplace safe for those invited onto the premises for business purposes) are alternative theories which could be raised. Physicians or employees who are positive for HIV may be considered unfit for performing invasive procedures which involve increased risks of exposure to patients. Health care employees or physicians who are positive for HIV or who have symptomatic sequelae of HIV may be considered handicapped, however, and may be protected by state and federal laws from discriminatory employment decisions if they are otherwise qualified for a job.[14]

Sociopolitical issues ● Given their technical expertise and role as providers of health care for the community, physicians as a group have a responsibility to present to policymakers clearly and accurately basic science and clinical research data about the probability, magnitude, and nature of the risk posed by HIV. Physicians must consider what will be the effect of the information presented on those listening. Those who consider proposals for mandatory testing for HIV, for quarantining those infectious for HIV, or for imposing treatment on those infected with HIV will look to physicians both for guidance in setting policy and for providing the clinical information that may be required under regulations enacted pursuant to such policies. It is important that physicians maintain a current knowledge base about the epidemiology, diagnosis, and treatment of patients who are infected with HIV.

HIV and AIDS raise issues covering a broad range of legal topics; many of these concerns are complex and untested in the law. Physicians should be alert to those areas where legal questions arise which include: patient care (taking an adequate social history and keeping up-to-date regarding the diagnosis and treatment options for HIV infected patients), informed consent, confidentiality of medical records, requirements for reporting transmissible diseases, use of life-prolonging medical treatments in terminally ill patients, discrimination in treating patients and in employment decisions, safety at the health care work environment, and public education.

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Incidence, symptoms, and signs of endometriosis in fertile and infertile women

Barry S. Verkauf, M.D.

ABSTRACT: One hundred forty-three women undergoing diagnostic laparoscopy for infertility and 251 fertile women having laparoscopic tubal sterilization were evaluated prospectively at the time of surgery for the presence or absence of endometriosis. A significantly higher proportion of infertile women (38.5%) were found to have endometriosis compared to fertile women (5.2%). A higher proportion of infertile women had endometriosis in all stages of the disease when categorized by the AFS classification, and there was a trend toward more advanced disease in infertile women. Relative risk estimates suggest that women with endometriosis are 11.4 times more likely to be infertile than women without endometriosis. Symptoms of pelvic pain, disordered bleeding, and abnormal findings on pelvic examination were more common in women found to have endometriosis and were more commonly present in infertile than fertile women. These observations strongly support the commonly held concept that endometriosis and infertility are associated.

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Endometriosis is an enigmatic, common disorder the precise occurrence of which is not known. Early studies based upon observations at laparotomy for gynecologic disease revealed incidences between 7 and 50%.[1-6] There is evidence that accurate recognition of endometriosis can be made visually by endoscopic methods.[7,8] The increased use of laparoscopy in recent times seems to have led to the diagnosis of this disorder with increasing frequency, and incidences of about 1 to 65% have been recorded depending upon the population studied.[9-15] Endometriosis has long been thought to be associated with infertility. This study assesses the incidence of endometriosis and symptoms and signs related to it in infertile and fertile women prospectively evaluated by laparoscopy.

Materials and methods ● Between February 1984 and September 1985, 143 women undergoing diagnostic laparoscopy for infertility and 251 fertile women having laparoscopic tubal sterilization were evaluated prospectively by 14 board certified gynecologists for the presence or absence of endometriosis. Careful search of the abdominal and pelvic peritoneum was made at laparoscopy for the presence of typical peritoneal raspberry or dark endometriotic foci with or without the associated rust staining, adhesions, or ovarian enlargement often seen with this disease. Diagnosis was made only when the findings were unequivocal. Biopsy confirmation was not required. The findings were recorded at the time of surgery, and the extent of the disease was categorized by the original American Fertility Society classification[16] in use at the time. Information was similarly recorded from the patient's clinical record regarding the presence or absence of symptomatology and physical findings commonly associated with endometriosis.

Differences in frequency of characteristics between fertile and infertile populations were made by chi square analysis. The relative risk of infertility associated with endometriosis was estimated by the odds ratio with confidence limits calculated by the method of Woolf.[17]

Results ● *Patient characteristics.* The mean age of the infertile group was 30.6 years (range 22-38) and of the fertile group 33.6 years (range 21-45). The median parity of fertile women was 2 - 0 - 0 - 2. Of the infertile women, 71.1% had primary infertility, and 73% of women with endometriosis had never conceived. Of the infertile women, 99.3% were Caucasian as were 94.7% of the fertile group ($p < 0.05$). One black woman was infertile, and 13 black women underwent sterilization.

Clinical findings. A significantly higher proportion of infertile women (38.5%) were found to have endometriosis compared to fertile women (5.2%). Of infertile women, the disease was Stage I in 36, Stage II in 12, and Stage III in seven. Ten fertile women had Stage I disease and three Stage II. In AFS Stage I, II, and III disease, a higher proportion of infertile women had endometriosis than did fertile women. No patient in this study had Stage IV (extensive) disease (Fig. 1).

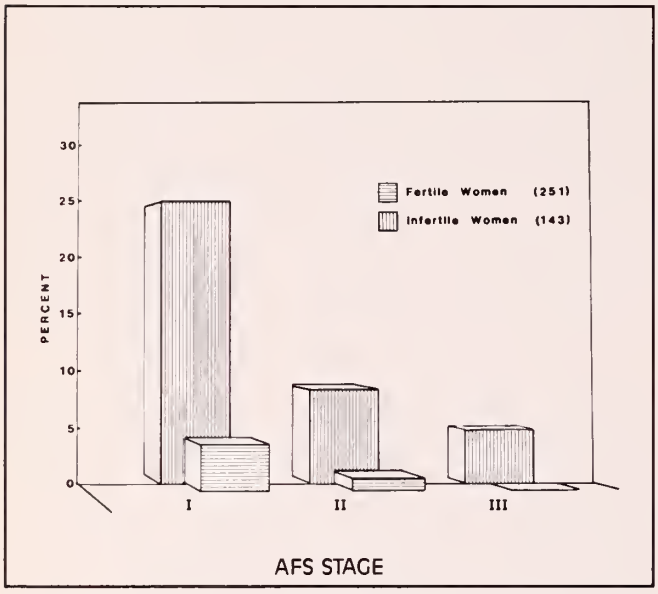


Fig. 1—Incidence of endometriosis in all women studied.

There was a clear trend towards more advanced disease in the infertile group, although this did not achieve statistical significance (Fig. 2). Similarly, when categorized by AFS score, a higher incidence of infertile women was found in each category, and a higher proportion of infertile women tend to have advanced disease, although the differences are not statistically significant (Figs. 3 and 4). The relative risk of infertility in women with endometriosis as estimated by the odds ratio is 11.4 with 95% confidence limits of 6.0 and 22.0.

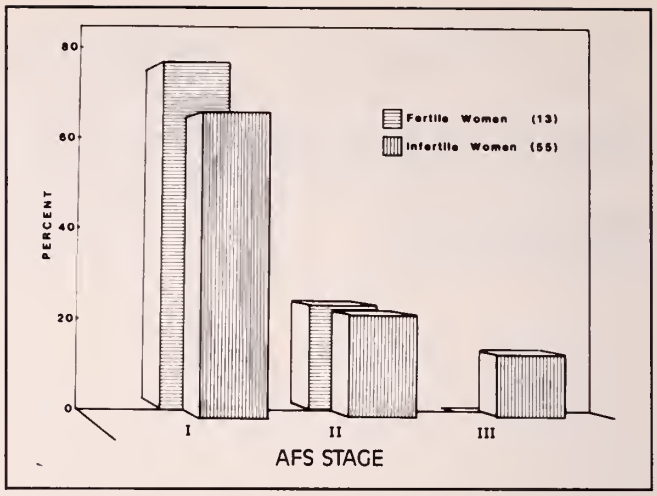


Fig. 2—Incidence of endometriosis by AFS stage in those women found to have endometriosis at laparoscopy.

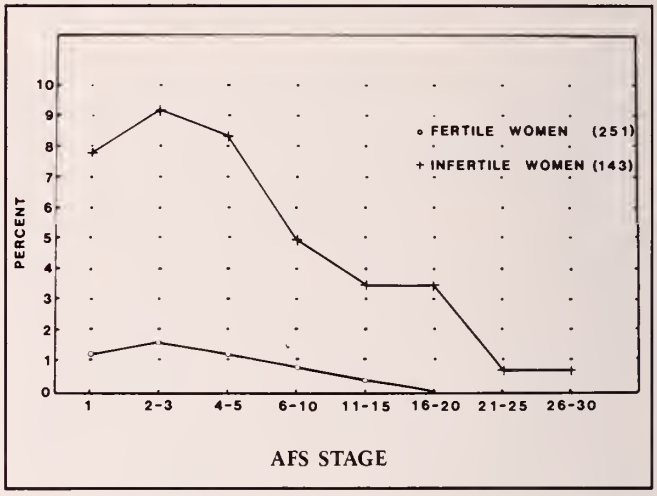


Fig. 3—Incidence of endometriosis by AFS score in all women.

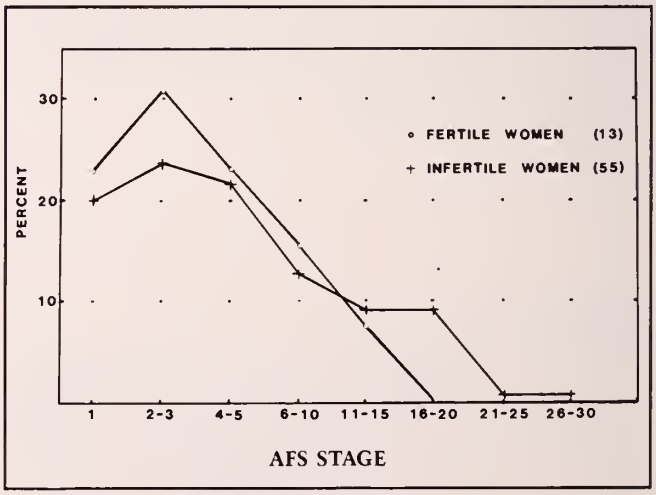


Fig. 4—Incidence of endometriosis by AFS score in those women found to have endometriosis at laparoscopy.

Table 1.—Incidence of Symptoms and Physical Findings Commonly Associated with Endometriosis in All Patients (N = 394).

	Endometriosis Present		Endometriosis Absent		
	(n = 68)	%	(n = 326)	%	
Dysmenorrhea	(27)	39.7	(33)	10.1	$p < 0.0001$
Dyspareunia	(5)	7.4	(14)	4.3	ns
Dyschezia	(2)	2.9	(3)	0.9	ns
Metrorrhagia	(8)	11.8	(17)	5.2	$p < 0.05$
Menorrhagia	(4)	5.9	(7)	2.2	ns
Uterus, Fixed, Retroverted	(7)	10.3	(4)	1.2	$p < 0.001$
Adnexal Thickening	(10)	14.7	(21)	6.4	$p < 0.05$
Ovarian Enlargement	(5)	7.4	(7)	2.2	$p < 0.05$
Nodular Uterosacral Ligament	(15)	22.1	(1)	0.3	$p < 0.0001$
Nodular Cul-de-sac	(19)	27.9	(2)	0.6	$p < 0.0001$
One or more of above	(44)	64.7	(11)	21.8	$p < 0.0001$

Table 2.—Symptoms and Physical Findings Suggesting Endometriosis.

	Infertile Women		Fertile Women		
	(n = 143)	%	(n = 251)	%	
Dysmenorrhea	(30)	30.0	(29)	11.6	$p < 0.05$
Dyspareunia	(12)	8.5	(7)	2.8	$p < 0.05$
Dyschezia	(3)	2.1	(2)	0.8	ns
Metrorrhagia	(6)	4.2	(17)	6.8	ns
Menorrhagia	(2)	1.4	(9)	3.6	ns
Fixed Uterine Retroversion	(8)	5.6	(3)	1.2	$p < 0.05$
Cul-de-sac Nodularity	(12)	8.4	(4)	1.6	$p < 0.001$
Uterosacral Ligament Nodularity	(17)	11.9	(4)	1.6	$p < 0.001$
Adnexal Thickening	(20)	14.7	(11)	4.4	$p < 0.01$
Ovarian Enlargement	(5)	4.2	(5)	2.0	ns
One or more of above	(62)	43.4	(53)	21.1	$p < 0.0001$

All symptoms and physical findings traditionally considered to be suggestive of endometriosis were more common in women found to have this disease than in those in whom it was absent (Table 1). Moreover, with the exception of menorrhagia and metrorrhagia, infertile women were more likely to present with these symptoms and signs than were their fertile counterparts (Table 2). Of 394 women evaluated laparoscopically, 68 were found to have endometriosis. Of these women with endometriosis, 23.5% had only symptoms suggestive of it; 17.7% had only physical signs suspicious for it; 23.5% had both symptoms and signs; and 35.3% had neither. Of 326 women found to be free of endometriosis, 14.4% had suggestive symptoms (ns); 5.2%, suspicious signs ($p < 0.001$); 2.2%, both ($p < 0.0001$); and 78.2% neither ($p < 0.0001$).

Of the 143 infertile women, 17.5% had symptoms commonly associated with endometriosis, 15.4% had suspicious physical signs, 10.5% had both, while 56.6% had neither. Comparable incidences of symptoms and signs suggestive of endometriosis in 251 fertile women were 15.1% (ns), 2.8% ($p < 0.0001$), 3.2% ($p < 0.01$), and 78.9% ($p < 0.0001$), respectively.

One or more symptoms or signs suggesting endometriosis were present in 61.8% of infertile women and 76.9% of fertile women found to have endometriosis at laparoscopy (ns). By constrast only 30.7% of infertile women and 18.1% of fertile women without endometriosis recognized at laparoscopy had one or more suggestive symptoms or physical findings ($p < 0.05$).

Discussion • This prospective study evaluates a large number of fertile and infertile women of similar socioeconomic status undergoing laparoscopy during a concurrent time frame at one hospital. The clearly significantly higher incidence of endometriosis of 38.5% in infertile women compared to 5.2% in fertile women is consistent with prior observations in studies which were retrospective in nature or involved smaller numbers of participants (Table 3). The relative risk estimates in this study suggests that women with endometriosis have an approximately 11 fold greater likelihood of being infertile than women without endometriosis. The magnitude of the risk estimates suggests that the association between infertility and endometriosis is unlikely to be due to chance. As in the findings at the Mayo Clinic,[15],

Table 3.—Incidence of Endometriosis Found at Laparoscopy.

Author	Year	Infertile		Fertile	
		(n)	%	(n)	%
Peterson and Behrman[9]	1970	(204)	33.3		
Hasson[10]	1976	(66)	22.7	(299)	1.3
Stock[12]	1978			(226)	4.0
Drake and Grunert[13]	1980	(38)	47.4	(43)	4.7
Strathy et al[15]	1982	(100)	21.0	(200)	2.0
Present Study	1986	(143)	38.5	(251)	5.2

there is a trend in our data toward more advanced endometriosis in women who are infertile. While this trend is a clear one, it does not achieve statistical significance, probably related to sample size.

Endometriosis has been thought to be more common in white women and in women of upper socioeconomic class. However, Lloyd[1] reported a similar prevalence at laparotomy in white and black private patients. Moreover, endometriosis has been found not uncommonly in black women complaining of pain, infertility, and other gynecologic symptoms.[11,14] While this study shows a higher percentage of black women in the fertile than in the infertile group, incidence findings are not changed in any category when the groups were evaluated by race.

The overwhelming majority (73%) of barren women in this study with endometriosis had primary infertility consistent with prior reports.[15,18] While pregnancy has been thought by some to have an ameliorating influence on endometriosis, there is evidence that its effect is variable and unpredictable.[19] It seems unlikely that prior pregnancy exposure could account for the large difference in incidences of endometriosis between fertile and infertile women in this study.

Oral contraceptive use has been suggested to improve endometriosis. While prior or current use of estrogen-progestin combinations were not investigated in the patients in this report, Strathy et al[15] did not find the use of oral contraceptives to significantly influence similar incidence findings in their patients.

Of interest is the observation that the majority of women in this study with endometriosis had mild disease. This was true of infertile as well as fertile women and is consistent with findings previously reported in women similarly studied by laparoscopic techniques.[9,13,15] Perhaps this should not be surprising since laparoscopy is increasingly frequently used to evaluate infertile women without apparent cause who, like women undergoing elective sterilization, often have no significant gynecologic symptomatology or physical findings. While it is easy to understand how endometriosis of advanced degree may contribute to infertility by distorting anatomy and altering tubal or ovarian function, the mechanism by which mild endometriosis might contribute to infertility remains unclear. Muse and Wilson[20] have recently reviewed a number of proposed potential mechanisms including altered prostaglandin secretion, disordered ovulatory events, hyperprolactinemia, increased incidence of spontaneous abortion, autoimmune phenomena, and altered macrophage physiology. The value of early treatment of mild endometriosis has been questioned,[21] but a recent analysis by Olive and Haney[22] substantiates the long-standing impression that fecundity rates in patients with endometriosis, even of mild degree, are reduced. Recent evidence acquired by scanning electron microscopy suggests peritoneal involvement with endometriosis is more widespread than is able to be appreciated visually.[23]

Pain, disordered bleeding, infertility, and palpable pelvic abnormalities are known to be common in women with endometriosis. All symptoms and signs usually associated with this disorder were found to be more frequent in patients in this study who were found at laparoscopy to have endometriosis. With the exception of metrorrhagia and menorrhagia, they were more common in infertile than fertile women. Although not significantly different, the reason for metrorrhagia and menorrhagia occurring more commonly in fertile women is unclear. In this study, of all women found to have endometriosis at laparoscopy, 23.5% had at least one symptom to suggest it, 17.7% had physical findings suspicious of it, 23.5% had both symptoms and signs, but 35.3% had neither. Similarly, of infertile women found to have endometriosis, 61.8% had one or more symptoms or signs suggestive of this disorder, but 38.2% had none. At times, the only clinical suspicion for endometriosis is unexplained infertility.

In summary, there is a significantly higher incidence of endometriosis in infertile women when compared to women who have no impairment in reproductive performance. Fertile and infertile women with endometriosis are significantly more likely to have symptoms and physical findings classically associated with it, and infertile women are significantly more likely to have symptoms and signs typical of this disease than are their fertile counterparts. The risk of being infertile is 11 times greater in women who have endometriosis than in those who do not. These observations strongly support the commonly held concept that endometriosis and infertility are associated.

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Detection of right atrial thromboembolism by two dimensional echocardiography

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ABSTRACT: Acute pulmonary embolus is an insidious and frequently unrecognized problem. Two-dimensional echocardiography has gained widespread usage in the evaluation of patients who are acutely ill. There have been reports in the literature of direct visualization of a probable thromboembolus in the right atrium and right ventricle using two-dimensional echocardiography. This is a report of the clinical, echocardiographic and pathologic features of a patient who was found to have a right atrial thrombus as well as a pulmonary embolus. The diagnosis of right atrial thromboembolus was made with two-dimensional echocardiography.

The echocardiographic properties of thromboembolus are distinctive from other right-sided cardiac masses. They are highly mobile with dynamic changes in form lacking a discrete attachment, moving freely in the right side of the heart.

Because of the limited experience with thromboembolism it is not clear whether medical management with thrombolytic agents or anticoagulation is superior to surgical intervention. Patients who are detected by echocardiography to have a right atrial thromboembolism are at significant risk for a fatal cardiopulmonary event.

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Acute pulmonary embolus is an insidious and frequently unrecognized problem. Patients present with chest pain and dyspnea. Massive pulmonary embolism can be responsible for syncope or even sudden cardiac death.

Two-dimensional echocardiography has gained widespread usage in evaluation of patients who are acutely ill. Echocardiography, however, has played only a minor role in diagnosing acute pulmonary embolus. Recently, direct visualization of thromboemboli in the right atrium and right ventricle has been reported using two-dimensional echocardiography.[1-19] This is a report of the clinical, echocardiographic, and pathologic features of a patient who was found to have a right atrial thrombus, as well as a pulmonary embolus. The diagnosis of the thrombus was made with two-dimensional echocardiography.

Case report • A 63-year-old black female with a five-year history of angina presented with a sharp pain, described as "sticky-like", occurring substernally in the epigastrium and radiating into the neck and shoulder. The patient had no previous history of myocardial infarction. She had been treated with a calcium channel blocker and showed improvement in symptoms of chest discomfort. Six days prior to admission, a choking feeling developed, also discomfort in the upper abdomen and lower chest which radiated into her back. The symptoms were initially mild so she did not use nitroglycerin. Because they increased in intensity, she was hospitalized with a diagnosis of unstable angina.

She had a ten-year history of hypertension which was treated with Inderal 10 mg three times a day and Dyazide. She had diet-dependent diabetes.

On physical examination, the blood pressure was 100/60 and pulse 110 and regular. She was afebrile

with a respiratory rate of 20. There was no jugular venous distension or carotid bruits. The lungs were clear to auscultation and percussion. The PMI was not displaced. There was no murmur, gallop, or click appreciated. The abdominal aorta was easily palpable but did not seem to be tender or enlarged. There was no organomegaly, clubbing, cyanosis, edema, or obvious tenderness in the extremities. The pulses were symmetric and full.

The electrocardiogram revealed a sinus rhythm with nonspecific ST - T wave changes. The CBC was normal. The LDHs were elevated at 259 and 252 respectively. The chest x-ray showed a normal heart size and clear lung fields.

The patient was admitted to the Coronary Intensive Care Unit where an acute myocardial infarction was ruled out with serial EKGs and enzymes. Abdominal ultrasound, upper GI, thyroid function studies, and pyrophosphate scan of the heart were all normal. Cardiac telemetry showed a tendency toward sinus tachycardia. While in the Unit, the patient complained of intermittent chest discomfort and shortness of breath. She was hypotensive with blood pressure in the 90 to 100 systolic range. Cardiac consultation was obtained. The patient was believed to have unstable angina; echocardiography and possible cardiac catheterization were recommended. Echocardiography was advised to assess left ventricular function and severity of any segmental wall motion abnormalities.

Echocardiographic findings ● Two-dimensional echocardiogram revealed a mass in the right atrium which was believed to represent a thromboembolus versus a myxoma (Fig. 1). The mass was noted to be elongated and fusiform in character, with a lack of discrete attachment point. The acoustic density was also less than that of normal myocardium and distinct from the acoustic properties of a myxoma. The mass probably represented a right atrial thromboembolus. The echocardiogram also demonstrated pulmonic valve motion compatible with pulmonary hypertension. The patient had a dilated right ventricle with a right ventricular volume and pressure overload pattern. The left ventricle was thickened with virtual cavity obliteration in systole, and the aortic valve was thickened without stenosis.

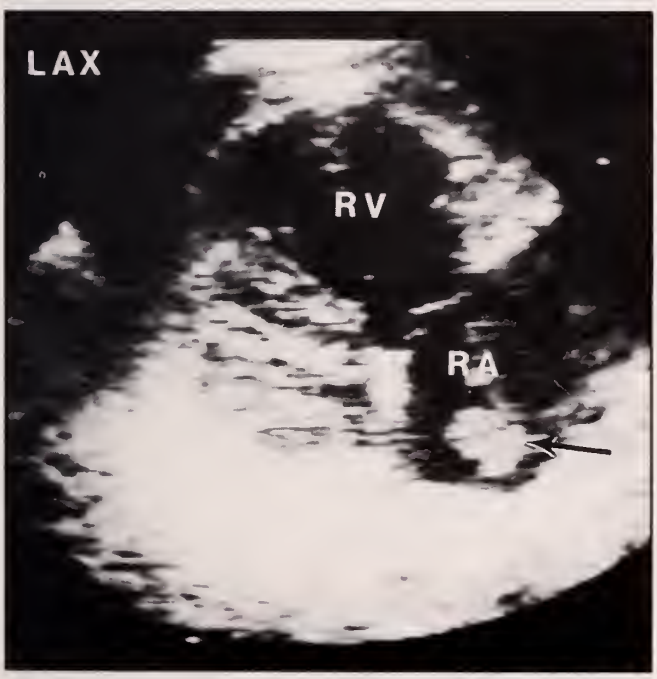


Fig. 1 — Two-dimensional long axis (LX) view of the right atrium (RA), tricuspid valve, and right ventricle (RV). Indicated at the arrow is a large, mobile, fusiform mass representing the thromboembolus.

Pulmonary artery angiography ● Angiograms were performed of the pulmonary artery and right atrium. Both demonstrated not only a right atrial clot but also a thrombus in the right ventricle and right pulmonary artery (Fig. 2).



Fig. 2 — Angiogram of the right atrium, right ventricle and pulmonary arteries demonstrate filling defects interpreted to represent clot at the apex of the right ventricle. There are small linear defects in the right atrium which were interpreted to represent adherent clot. The filling defect seen in the right pulmonary artery represents a saddle embolus with poor flow to the left lung. No definite clot was seen in the left pulmonary artery.

Therapy ● Initially upon admission to the Coronary Care Unit, she was treated with long-acting nitrates, calcium channel blockers, and intravaneous morphine

sulfate to relieve her chest discomfort. Following interpretation of the echocardiogram, she was placed on anticoagulation therapy in the form of intravenous heparin.

Surgical findings ● Upon arrival in the operating room, the patient was hemodynamically stable. Exposure was obtained with a median sternotomy. Cardiopulmonary bypass was begun, using the pump suckers for venous drainage to allow removal of the right atrial thrombus without dislodging it. There was a long organized thrombus in the right atrium morphologically of an iliofemoral origin. Following evacuation of the right atrium and conversion of the cariopulmonary bypass to a more standard venous drainage, the pulmonary artery was opened. The embolus was then removed from the right pulmonary artery. It was found to be a more rounded organized thrombus (Fig. 3). Weaning the patient from cariopulmonary bypass required vigorous catecholamine support. Hemodynamic instability precluded the planned direct clipping of the inferior vena cava.



Fig. 3 — Pathologic specimen obtained from the right atrium at the time of surgery.

Postoperatively, hemodynamic instability persisted with elevated pulmonary artery pressures. It was possible to gradually reduce catecholamine support. The postoperative chest x-ray demonstrated flooding of the embolectomized right lung. There seemed to be a gradual improvement over 48 hours until a sudden episode of ventricular fibrillation occurred from which she could not be resuscitated.

Permission for postmortem examination could not be obtained.

Discussion ● This case represents an example of a right atrial thromboembolization, apparently from the deep venous system, in an elderly black female with history of diabetes, atherosclerotic heart disease, and angina pectoris. The working diagnosis, until the echocardiogram was performed, was unstable angina. The patient had actually been scheduled for cardiac catherization. The two-dimensional echocardiogram was diagnostic of a right atrial thromboembolus. Angiography confirmed this (Fig. 2). After reviewing the literature, a decision was made to treat the patient surgically.

Acoustic properties of thromboembolus ● Echocardiographic appearance of the right atrial mass in our patient was identical to the description by Redish and Anderson of a similar right atrial thromboembolus.[14] They noted "an elongated fusiform character of the mass with dynamic changes in form, lack of discrete attachment point, and free movement of the mass within the right side of the heart." To this, Armstrong added that the acoustic density of the mass described in their case was less than that of the normal myocardium and was distinct from the acoustic properties of myxomas in their experience. "These masses did not have the acoustic properties of a chronic left ventricular thrombus, but rather the acoustic properties of relatively fresh thrombus."[18] Chronic left ventricular thrombi are described as being flat and nonmobile.[22-23] They appear to be bright and "grainy", and exhibit smooth distinct margins from the ventricular cavity.[23] The acoustic density is about the same as or slightly denser than that of normal myocardium.[23]

Other intracardiac masses with which a thromboembolus could be confused would include primary and secondary intracardiac tumors or vegetations.[19-21] Right atrial myxomas have a more homogeneous and a slightly denser acoustic pattern than do thromboemboli and usually have an attachment point on the atrial septum.[21] Most of the vegetations which would be associated with right heart masses would clearly be seen attached to the tricuspid valve with their acoustic density being greater than that of a thromboembolus.[18]

Echocardiography and right atrial masses ● The diagnosis of a right atrial mass can be made by routine angiography, computerized tomography, and probably by digital vascular imaging.[24-27] In the future, as nuclear magnetic resonance becomes more widely used, it may also detect right atrial thromboembolism. In our case, an angiogram confirmed the echocardiographic findings. As suggested by the literature, most diagnoses of right atrial thromboemboli have been achieved through the use of echocardiography.[18]This is probably due to several factors. First, the two-dimensional echocardiogram is often used as an initial tool in the evaluation of patients with cardiac symptomatologies such as chest pain and dyspnea. Echocardiography is indicated because it assesses left ventricular function and can rule out occult valvular disease. Echocardiography is diagnostic of coronary artery disease, if a segmental wall motion abnormality or scar is found. Second, the echocar-

diogram, being a noninvasive examination, is relatively inexpensive and safe. Third, two-dimensional echocardiograms are available in most community hospitals.

Patient management ● In Armstrong's review of 20 cases of right atrial thrombus, the patient outcome was, indeed, poor.[18] In five patients, no specific therapy was directed at the thromboembolus. All the patients died. At the time of autopsy, all had massive, and often multiple, pulmonary emboli. In eight patients, a diagnosis of a right atrial thrombus or a right atrial mass associated with pulmonary emboli was made. These patients were treated with either heparin or another thrombolytic agent. Of these eight patients, four survived, showing resolution of the right-sided cardiac mass on repeat echocardiography. One death occurred after echocardiographic resolution of the mass.[11] At the time of autopsy, this patient had multiple large pulmonary emboli.

Seven patients, like our patient, had prompt surgical exploration with removal of the thromboembolus. In all, a large right-sided cardiac thrombus with large pulmonary emboli was found and surgically removed. Six of these seven patients survived surgery. One death was noted, involving a woman with longstanding pulmonary hypertension and occurring 48 hours after technically successful cardiac surgery.[10] In Armstrong's review, two patients are presented. The first patient did not receive anticoagulation because of uncertainty of the exact diagnosis and the absence of clinical evidence of pulmonary emboli.[18] Cardiac catherization had been planned for the subsequent day. The patient died while being evaluated in x-ray. The second patient was treated with streptokinase and died soon after institution of therapy.[18]

Cameron et al, in their case report, favored surgical removal of the thromboembolus as soon as it was recognized.[19] Two of their patients showed evidence of hemodynamic compromise due to the pulmonary embolus. The thrombi were so large and mobile the patients were felt to be at risk for sudden death because of the potential for major pulmonary embolism or obstruction to the right heart flow. Cameron et al cited examples in the literature where anticoagulation therapy or thrombolytic therapy, as in the case of Armstrong's patient, did not protect the patient from recurrent pulmonary embolism or the risk of sudden death. In their review, they suggested that the risk may be greater when the thrombus was seen floating freely in the right heart chambers.

Surgical considerations ● Pulmonary embolic disease continues to be a major frustration for the cardiovascular surgeon. Limiting the indications for embolectomy to the moribund hemodynamically unstable patient has been associated with poor results. The effectiveness of medical therapy in most instances precludes extending the indications for embolectomy except in limited circumstances.

Cases such as the one reported here raise the questions of whether or not echocardiography shouldn't be a routine part of the management of pulmonary embolus, and whether pulmonary embolectomy can be applied more aggressively in the setting of right atrial thromboembolism.

Recurrent thrombolism was clinically suspected as the cause of death in our case. The lifesaving surgical step is removal of the atrial thrombus. The literature reviewed indicates a poor prognosis with anticoagulant or thrombolytic therapy in the presence of a right atrial thrombus.[18-19] Pulmonary embolectomy may be unnecessary and harmful. Prevention of further pulmonary embolism becomes especially important, especially if the pulmonary vascular bed is compromised. In the future, we would recommend insertion of an inferior vena cava filter from one of the common femoral veins, if the patient is hemodynamically stable. That can best be done prior to right atrial embolectomy.

Conclusion ● Right atrial thromboemboli are associated with a high mortality. Two-dimensional echocardiography appears to be the most useful method for recognizing their presence. The acoustic properties of thromboemboli are distinctive from other right-sided cardiac masses. They have dynamic changes in form, lack a discrete attachment point, and are highly mobile, moving freely in the right side of the heart. Because of limited experience with these patients, it is not clear whether medical management with thrombolytic agents or anticoagulation is superior to surgical intervention. It appears from the literature that when a right atrial thromboembolus is detected by echocardiography, patients are at significant risk for a fatal cardiopulmonary event.

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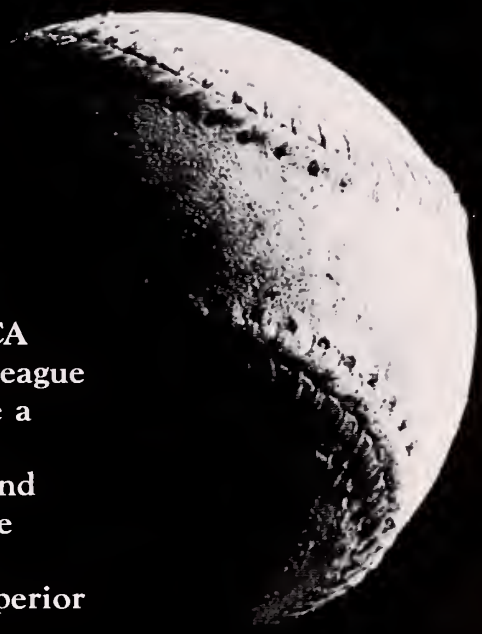
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High Quadriplegia Program

A medical symposium addressing the acute and rehabilitative care of the C-1 through C-4 high quadriplegic. Hosted by Shepherd Spinal Center in Atlanta, now the nation's largest dedicated spinal cord injury hospital. Issues to be investigated include: medical, psychosocial and high tech approaches to care and rehabilitation. Special emphasis on ventilator weaning, the interdisciplinary care approach, phrenic nerve pacer implants and community reintegration.

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- The Therapeutic Value of Sensory Experience
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High Quadriplegia– The Ultimate Challenge

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Prognosis: Promising

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When 28 year-old Larry McAfee was brought to Shepherd Spinal Center as a result of a motorcycle accident in late 1985, he was classified as a C-1 complete spinal cord injury. He was suffering from severe burns on his right ankle, massive atelectasis, pneumothorax and pneumonia. Paralyzed instantly at the first cervical vertebrae below the brain stem, he required mechanical ventilation for breathing.



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SPECIAL ARTICLE

Impact of economic changes on Florida's health care system: The future of the practice of medicine

Robert W. Seligson, M.B.A.

The changes that have occurred in Florida's health care system over the last five years are unparalleled in the state's history. Today the health care marketplace is involved in a revolution in contrast to the evolution of the past. As the result of unprecedented pressures by government, industry, and consumers to contain costs, physicians are rapidly changing the mode in which they deliver services.

The Medicare program, which provides health insurance for over 19% of the population in Florida, utilizes up to 48% of health care services, thus playing a major role in financing and delivering care. Medicare is undergoing major budgetary reductions and policy modifications in an effort to address huge federal budget deficits. The impact of these changes are already being felt by the medical profession.

Another significant change pertains to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) reform proposal that would place a set fee upon health care services provided to CHAMPUS beneficiaries, the result of competitive bidding. The impact of changes will also be felt by Florida physicians, inasmuch as CHAMPUS beneficiaries comprise over 3.5% of Florida's existing population.[1]

Approximately 1.3 to 1.6 million of Florida's citizens are categorized as medically indigent.[2] Health care for them is a major legislative issue and will play a major role in changes occurring in the health care system.

The malpractice crisis has reached epidemic proportions in Florida and is affecting physicians and hospitals, and, ultimately, consumers of health care services. Its detrimental impact will continue as long as it is allowed to affect the affordability and accessibility of health care.

The spread of AIDS is becoming the number one health threat in Florida. Its effect on the financial and delivery aspects of health care is expected to have a devastating impact on the overall health care system.

Major corporations in the state maintain that health care costs, even with development and implementation of managed health care programs, have continued to rise steadily over the past several years, and consequently, they are emphasizing the development of mechanisms that will help contain them. Employers are requiring employees to take on more responsibility in financing their health care. Major corporations are pressuring the health care system to develop programs that will help control costs which have become a major portion of corporate operating revenue. All these changes will ultimately affect the quality of care, as well as create new problems for the private sector of medicine.

This article discusses the changing characteristics of the practicing physician and hospitals in Florida as related to Medicare, CHAMPUS, managed health care programs, malpractice, AIDS, indigent care, and the pressure from major corporations to contain health care costs through managed care.

Health care costs ● Physicians are expressing major concern regarding the emphasis upon cost containment in the delivery of health care. As a result of major budget reductions proposed by federal and state governments, funds available to provide quality care are rapidly diminishing.

According to the Health Care Financing Administration, health care costs are expected to reach

The Author
ROBERT W. SELIGSON, M.B.A.
Mr. Seligson is Director of Medical Economics, Florida Medical Association.

$1.5 trillion by the year 2000 which will represent 15% of the GNP.[3] During 1986 the inflation rate was approximately 1.9% as compared to a 7.5% for health care services. Causes of health care inflation can be attributed to the increasing costs of the development of medical technology, professional liability insurance, increased practice of defensive medicine, financing of indigent health care, rising cost of health care administration, and mandated health care benefits. Proposed mandated health care benefits are regularly being considered by federal and state legislatures. This adds to the cost of care.

Health care cost in the United States has increased faster than the consumer price index over the last six years representing a 12.5% increase in 1981, 11.0% increase in 1982, 6.4% increase in 1983, 6.1% increase in 1984, 6.7% increase in 1985, and 7.7% increase in 1986.[4] National health expenditures as a share of the gross national product was 10.8% in 1986 as compared to a 6.1% in 1965. Comparatively, other countries' health care expenditures as a percentage of the GNP include Sweden representing 9.6%, France 9.3%, Canada 8.5%, West Germany 8.2%, and Switzerland 7.8%.[5]

Medicare • In 1986 the Health Care Financing Administration spent $72 billion on the Medicare program; physicians received $22.1 billion of the total amount paid out for services.[6] Under Medicare Part B in Florida, the amount paid for physicians services increased from $1.25 billion in 1984 to $1.51 billion in 1986.[7] Administrative costs increased from $34 million in 1984 to $42.9 million in 1986.[8] Nationally, Medicare Part B, including both durable medical equipment and physician services increased from $20.37 billion in 1984 to $26.22 billion in 1986.[9] Medicare Part A expenditures for Florida hospitals increased from $2.5 billion in 1984 to $2.8 billion in 1986.[10]

Health care economists have considered the Medicare system of reimbursement as inflationary and since its creation, some type of control mechanism has been imposed on physician charges. Because emphasis is upon curtailing the federal deficit, major payment reforms are being considered including a DRG (Diagnostic Related Groups) system for radiologists, anesthesiologists, pathologists, and a RVS system for cognitive and procedural services, a national fee schedule which is favored by the Physician Payment Review Commission, and a program that would capitate physician groups on a geographical basis.

Pressures from lobbying groups such as the American Association of Retired Persons (AARP) and other senior citizen organizations to limit physician reimbursement to a "reasonable level" are being felt in national and state legislatures. The AARP believes that health care costs should be reduced through restructuring the current reimbursement system without increasing the burden of already high out-of-pocket costs.[11] AARP supports the creation of a payment system based on a National Medicare Physician Relative Value Scale consisting of a nationally defined unit of service which probably would not take into consideration geographical difference and costs of operating a practice in various locations in the country.[12]

Mandatory assignment is supported by the AARP. This limits the maximum amount a physician can charge to a Medicare patient and directs that he accept what Medicare recognizes as a "reasonable amount." Medicare's "reasonable charges" normally equates to a reimbursement of 50 to 55% of the actual charge. Several states have enacted mandatory assignment (three as of July 15, 1987). During the 1987 legislative session, the Florida Medical Association was successful in opposing mandatory assignment; however, it is likely to be a major issue in the 1988 session. Changes resulting from the Omnibus Budget Reconciliation Act of 1986 require nonparticipating physicians not to exceed a "maximum allowable actual charge" (MAAC) to Medicare beneficiaries which is similar to mandatory assignment.

In Florida a minimum of 44.8% of physicians accept assignment on a 100% basis. Those that accept assignment on a case-by-case basis amount to 67%, taking into account the individual financial and medical needs of the Medicare patient. Sixty-seven percent of total dollars paid out by Medicare during the second quarter of 1987 was on an assigned basis.

Proposed federal budget reductions, the AARP and other retired citizen organizations will continue to pressure the physician to accept discounted fees, ultimately lowering the realized net income generated by his practice to cover expenses such as PLI insurance and office overhead. Physicians and hospitals will be affected because Florida's 65-year-old and above population utilizes a large share of the health care services provided in the state. In the upcoming months, it will be essential for the Florida Medical Association to educate leadership of the AARP and other retired organizations regarding the difference between what Medicare recognizes as reasonable and the actual or necessary amount physicians must charge in order to cover their practice overhead sufficiently to provide quality care.

The effect of the statewide PRO upon hospital admission review will continue to place emphasis on containing health care costs by elimination of unjustified admissions under the Medicare program. However, recent HCFA guidelines have emphasized more the quality of services as opposed to cost containment. Implementation of this policy will strengthen the role of the PRO in monitoring health care services provided to senior citizens. It is too early to tell whether these proposed changes will truly place more emphasis on quality review as opposed to utilization review, but the sanction activity of the

PRO will continue to rise. The statewide PRO has recently contracted with HCFA to review Medicare HMOs; thus, further strengthening its peer review activities.

Medicare patients utilize the majority of health care services in Florida but on a national basis Medicare visits accounted for 35.2% of the physician's practice but only 23.1% of the revenues generated.[14] Medicare visits in the South accounted for 34.8% of total office visits and 22.6% of total revenues generated.[15] The American Medical Association, Socioeconomic Department, stated that "Although the average Medicare patient visits remained virtually unchanged from 1984 to 1985, the overall Medicare revenues decreased. While medical visits associated with hospital and patients declined significantly, Medicare patients are less likely to be seen in a physician's office and are more likely to be seen in the hospital."[16] Although physicians realize no change in Medicare visits as compared to total office visits, there was a net decline in revenues received. Medicare revenues are expected to decline significantly over the next several years as a result of proposed budget costs. The impact in Florida will be more severe than in the rest of the country.

CHAMPUS ● The Department of Defense has introduced a new managed health care program in an effort to establish some type of capitation program to limit the amount spent on CHAMPUS beneficiaries. Currently, Florida has approximately 450,123 beneficiaries in the CHAMPUS program.[17] The Department of Defense's new program is a six state, three region initiative pilot project which includes Hawaii/California, North Carolina/South Carolina, and Florida/Georgia. Bids have been received and are currently being reviewed; however, several bidders have withdrawn their proposals because of the major risk that would be incurred and the recent policy change that would tie hospital reimbursement to Medicare DRGs. It is anticipated that a contract will be awarded in early fall. The program centers around an annual fee to provide health care services to retirees and dependents in place of the current system based upon a "billed-charge" basis. Nationally, CHAMPUS costs an estimated $1.8 billion in 1986. This is clearly another government initiative to place a limit on expenditures for health care costs.

Managed health care programs ● Major corporations are continuing to place emphasis on curtailing the rising costs of health care benefits in Florida. Coalition activity in several cities is devoted to developing utilization review mechanisms that will enable businesses to gain a better hold on the cost of providing health benefits to their employees. This includes not only contracting with managed health care programs but also developing second surgical opinion programs. Other programs include increasing the amount of the deductible to the employee as well as requiring the employee to take on a greater responsibility in the management and financing of his/her health care. During 1986 health benefits rose an average of 7.7% for employers in the South Atlantic region representing an approximate cost of $1,692 per employee.[18]

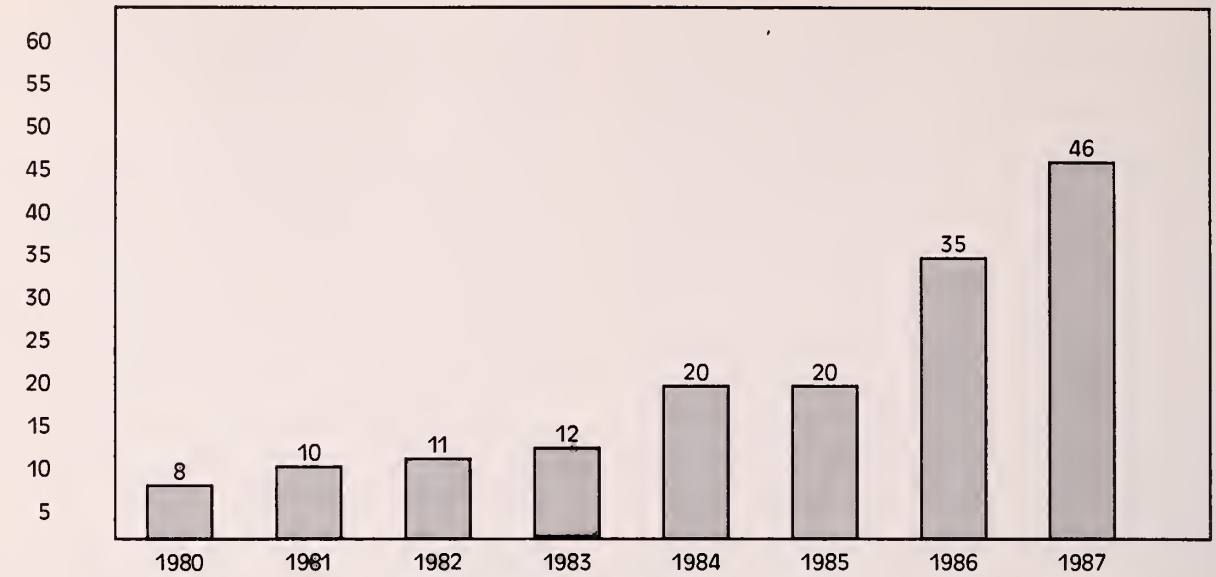
The growth of managed health care systems continues at a rapid rate. Nationally PPO (Preferred Provider Organization) enrollment has increased from approximately 1.3 million to the current estimate of 5.8 million people. There are 26 PPOs in Florida. Nationally in 1970 there were 33 HMOs representing an enrollment of 3 million. From 1970 to 1986, HMO development increased to 595 representing 23.7 million people. Enrollment increased 270% during the 16 year period. In 1987 there are an estimated 700 HMOs in the United States representing 28 million people.

The State of Florida has experienced phenomenal HMO growth — well above the national average. In 1980 there were eight HMOs representing 145,000 people. In 1982 there were 11 HMOs representing 190,000 people. As of February 1987, there were 46 HMOs representing an enrollment of 1,343,270 or 11% of the population with the ten largest plans including IMC representing 73.6% of the total HMO enrollment.[20] Details of Florida HMO Growth are listed in Tables 1 and 2. Of the 46 HMOs, 27 are IPA (Independent Practice Association), 11 are staff in which physicians are salaried employees, and two are the group model representing over 16,000 physician contracts and over 400 hospital contracts.[21]

Currently, employer opinion is mixed regarding the effectiveness of HMOs and other managed health care programs in containing health care costs. Some feel that programs help contain costs while others feel they actually increase costs. Employers utilize several carriers which ultimately increase the cost of administering benefits. Some report increases in benefits up to 15%. The introduction of managed health care programs has also brought on other cost saving mechanisms such as co-payment and deductible requirements. These programs will likely diversify their product mix and adapt their plans to continue to meet the needs of business. Most smaller HMOs with enrollment of less than 30,000 will not survive over the next several years due to the capitalization requirement needed to remain solvent. The HMO of the future may not even resemble its current format.

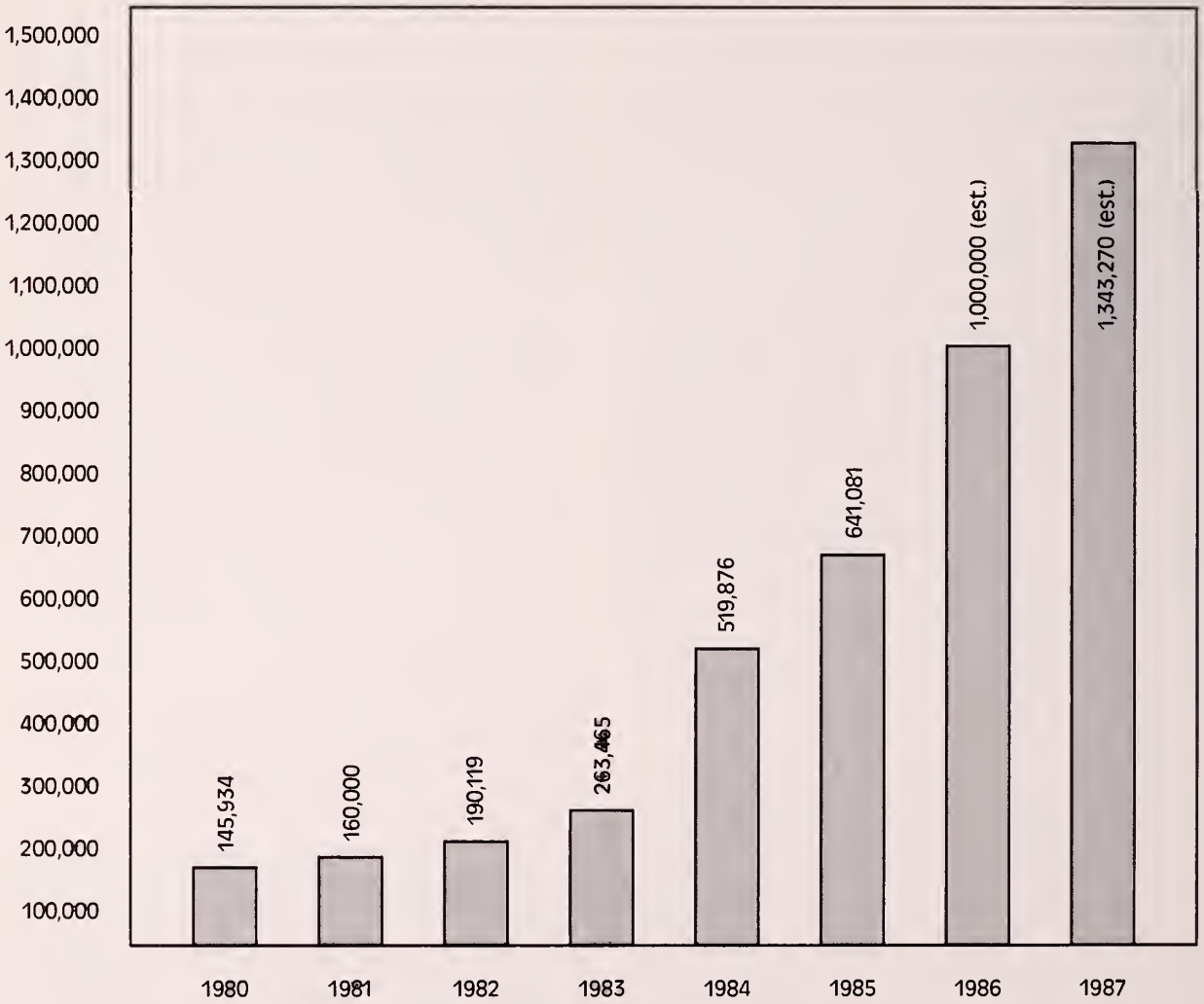
In a study conducted by Judith Mattson, Inc., for the Florida Medical Association, several CEOs of major Florida corporations were interviewed. An executive in South Florida said, "As long as our firms pay the bills, we have the leverage to shape and define relationships." Assuredly, major employers in Florida will continue to play a major role in the development, financing, and organization of health care services.

Table 1. — Florida HMO Growth.



SOURCE: Florida Department of Insurance

Table 2. — Florida HMO Enrollment Growth



SOURCE: Florida Department of Insurance
Judith Mattson, Inc.
Health Plan Development and Management Services

Table 3.—Frequency of Claims per 100 Physicians for Selected Specialties, 1980-1984.

Specialty	1980	1981	1982	1983	1984	Percent Increase (1980-84)
General practice	10.4	13.3	14.0	14.4	12.2	17
Internal medicine	12.9	18.2	21.6	23.1	23.7	84
Pediatrics	15.2	20.3	25.1	21.5	19.3	27
General surgery	27.6	32.2	35.6	29.4	34.1	24
Neurosurgery	48.2	56.3	61.8	87.6	88.6	84
Ophthalmology/surgery	19.3	19.5	25.1	27.8	31.4	63
Orthopedic surgery	36.8	50.4	56.1	46.5	39.1	6
Plastic surgery	48.6	51.6	60.4	42.1	47.2	(3)
Obstetrics/gynecology	51.6	53.5	52.9	51.3	44.0	(15)
Radiology	12.5	13.6	22.6	23.2	29.6	137
Psychiatry	10.5	13.2	17.7	9.8	10.0	(5)
Anesthesiology	24.4	28.0	30.4	28.4	23.3	(5)
Pathology	7.2	10.4	10.8	13.8	11.0	53

Source: United States General Accounting Office
Report to Congressional Requesters
Medical Malpractice: Case Study in Florida, December, 1986 - p. 20.

Malpractice ● The current malpractice problem is seriously threatening the delivery of quality medical care in Florida. Physicians are not only faced with high malpractice premiums but also are experiencing difficulty in obtaining adequate coverage.

Nationally, in 1985, there was 10.1 claims filed per 100 physicians and 21 claims per 100 for every OB/GYN.[22] (See Table 3 for details on frequency per 100 physicians for Florida selected specialties.) Since 1982, premiums have increased at an average annual rate of 21.9% for all doctors and 28.8% for OB/GYNs.[23] In 1986 the malpractice rate for Dade and Broward Counties for a general practitioner with no surgery was $10,521 versus $113,000 for a neurosurgeon. The remainder of the state experienced 33% lower rates.[24] The OB/GYNs in Dade and Broward counties incurred a 456% increase in premiums for the period 1980 to 1986 and neurosurgeons a 429% increase for this same time period.[25]

According to the AMA, adjusted for inflation, about one fourth of the increased revenues generated by the self-employed physician between the years 1982 to 1985 were used to pay the additional malpractice premiums.[26] On a national basis, revenue devoted to paying malpractice premiums increased from 3.1% in 1982 to 4.7% in 1985.[27] During the period of 1980 to 1986, all specialties in Florida had an increase in malpractice premiums ranging from 199% to 456%. (See Table 4 for other specialties insurance premiums in Florida.) The average paid claims for physicians in Florida increased from $80,566 in 1980 to $140,594 in 1984 or 75%.[28]

The frequency of malpractice claims per 100 occupied beds increased from an average of 2.1 in 1980 to 2.4 in 1984.[29] St. Paul reported that the frequency of claims for hospitals it insured in Florida averaged 3.8 claims per 100 beds and the pure premium increased 150% during the period 1981-1985. The frequency in claims against physicians rose from 20.8 to 26.1 per 100 physicians during the same period.[30] During 1986 approximately $3.6 billion was written in medical malpractice premiums. For this period, the current estimate of loss, taking into consideration the statutory underwriting losses after policyholder dividends, amounted to well over $1.5 billion.[31]

The average malpractice insurance cost for Florida hospitals per inpatient day increased by 99% between 1983 and 1985 and the average per bed cost by 93%.[32]

Nationally the average medical malpractice jury verdict increased from $220,018 in 1975 to $2,056,525 in 1986. The average product liability jury award increased from $393,580 in 1985 to $1,971,655 in 1986, according to Jury Verdict Research, Inc.[33]

An estimated 30 to 40% of all diagnostic procedures ordered by physicians are attributable to defensive medicine. Over 70% of these physicians indicate that they altered the way they practice medicine in order to protect themselves against lawsuits, according to an AMA survey. The cost of professional liability insurance in 1984 was estimated between $12.1 and $13.7 billion of total health care expenditures of $75.4 billion.[34]

The cost of defensive medicine in 1984 has been estimated as over $4,600 per physician.[35] In a recent study, it was estimated that each dollar of medical malpractice risk induces $3.50 of defensive medicine expenditures. This can be broken down as 39 percent for extra time with patients, 41 percent for additional follow-up visits, and 20 percent for extra record

Table 4.—Cost of Insurance* for Selected Specialties, 1980 and 1986.

Specialty	Territory	1980	1986	Percent increase
General Practice (no surgery)	1	$2,633	$10,521	300
	2	1,975	7,017	255
Internal medicine (no surgery)	1	2,633	10,521	300
	2	1,975	7,017	255
Pediatrics (no surgery)	1	2,633	10,521	300
	2	1,975	7,017	255
Psychiatry	1	2,633	10,521	300
	2	1,975	7,017	255
Pathology	1	2,633	10,521	300
	2	1,975	7,017	255
General practice (minor surgery)	1	4,655	15,665	237
	2	3,491	10,448	199
Internal Medicine (minor surgery)	1	4,655	15,665	237
	2	3,491	10,448	199
Pediatrics (minor surgery)	1	4,655	15,665	237
	2	3,491	10,448	199
Radiology	1	4,655	15,665	237
	2	3,491	10,448	199
Ophthalmology/surgery	1	8,076	20,809	158
	2	6,059	13,879	129
Anesthesiology	1	13,389	47,739	257
	2	10,043	31,837	217
Plastic surgery	1	13,389	53,672	301
	2	10,043	35,794	256
General surgery	1	13,389	53,672	301
	2	10,043	35,794	256
Orthopedic surgery	1	21,355	71,474	235
	2	16,021	47,667	198
Obstetrics/gynecology	1	16,045	89,274	456
	2	12,036	59,537	395
Neurosurgery	1	21,355	113,010	429
	2	16,021	75,367	370

Legend: Territory 1 - Dade and Broward Counties Territory 2 - Remainder of state (primary rating territory)

* Rates shown are those of the St. Paul Company for a $1 million/$1 million claims-made policy as of March 1, 1980, and January 1, 1986. A claims-made policy covers malpractice events that occur after the effective date of the coverage and for which claims are made during the policy period.

SOURCE: United States General Accounting Office, Report to Congressional Requesters Medical Malpractice: Case Study in Florida, December, 1986 - p. 18.

keeping.[36] St. Paul estimates a loss of between $10 and $15 million on its 1986 State of Florida's physician malpractice business. At current 1986 rates, the company anticipates a minimum loss of $20 million in 1987.[37] St. Paul reports that the frequency of claims reported since 1982 has averaged 24.4 per 100 insured doctors, well above the national average. In 1986, based on second quarter results, Florida claims increased to 26.4 per 100 insured doctors versus 17.2 per 100 insured doctors nationally, a 53% average increase.[38]

Florida's claim severity, St. Paul reported, rose 68% during the same five-year period, from 23,032 in 1982 to 38,709 in 1986, again based on second quarter results. The average payment, based on closed claims, increased from $23,283 in 1982 to $46,648 in 1986.[39] This does not include defense and other affiliated costs in bringing a suit to trial. St. Paul also reports that it paid more than $36 million in 1986 for losses and defense costs as compared to $26.2 million in 1985 and $9.7 million in 1984. There are currently over 1,800 claims still open that were submitted during the 1986 period.

Florida physicians pay the highest malpractice premiums in the country, while hospitals are also experiencing rapid increases in malpractice insurance. The hidden costs associated with prevention such as defensive medicine, extra record keeping, and additional diagnostic tests significantly contribute to the cost of professional liability and add to the overall cost

of delivering health care. In addition, practicing medicine in a litigious society adds stress and discomfort to physicians in this environment.

The Medical Injury Compensation Reform Act of 1975 in California clearly demonstrates that tort reform had a positive effect on limiting malpractice awards and premium increases. In order for this problem to be resolved, it is essential that the public be educated on the problems that are brought about by the current tort law and the effect it has on product and medical liability. Ultimately, the individual consumer pays the cost.

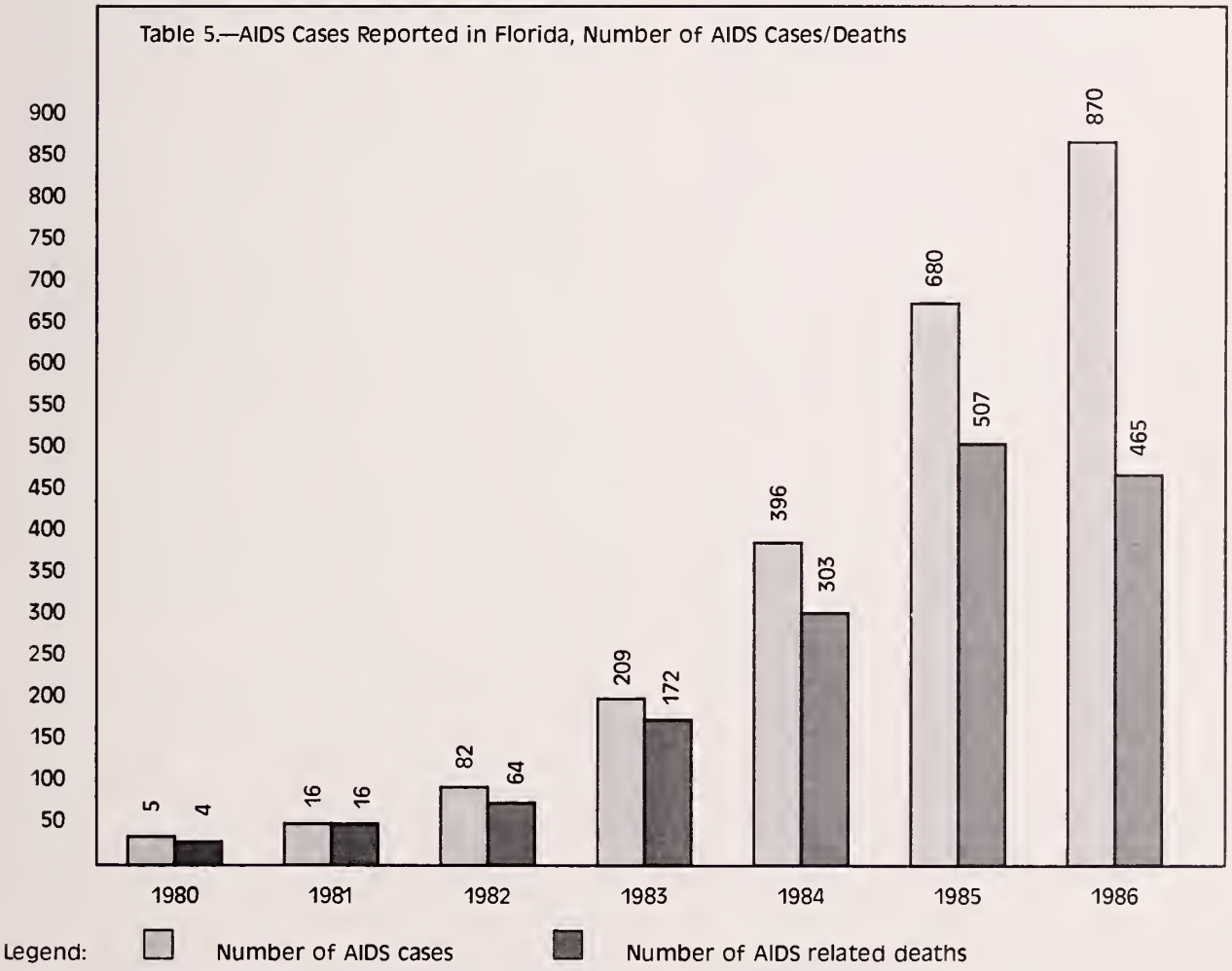
AIDS • As of June 22, 1987, the Centers for Disease Control ranked Florida third among states with the highest number of reported AIDS cases in the country. New York and California account for over 52% of the reported cases. Florida, as of July 1, 1987, had 1,097 cases for the year representing 7.1% of total cases and a cumulative total of 2,542 since 1981.[40] (Table 5) The top five cities in Florida reporting AIDS cases, as of July 1, 1987, were Miami 947, Ft. Lauderdale 291, Belle Glade 89, Key West 75, and Tampa 72. (Table 6) Two hundred additional AIDS cases are reported in Florida each month. Nationally, AIDS cases are projected to reach 1.5 million by 1991.[41]

Table 6.—Top 10 Cities in Florida Reporting AIDS Cases as of 7/1/87.

	City	Number of Cases
1.	Miami	947
2.	Ft. Lauderdale	291
3.	Belle Glade	89
4.	Key West	75
5.	Tampa	72
6.	West Palm Beach	70
7.	Jacksonville	63
8.	Orlando	56
9.	Hollywood	42
10.	St. Petersburg	36

SOURCE: Acquired Immune Deficiency Syndrome Surveillance Report, Department of Health and Rehabilitative Services AIDS Program, Disease Control, State Health Office

Table 5.—AIDS Cases Reported in Florida, Number of AIDS Cases/Deaths



SOURCE: Acquired Immune Deficiency Syndrome Surveillance Report, Department of Health and Rehabilitative Services, AIDS Program, Disease Control, State Health Office.

Of the 323,000 projected cases nationally of fully developed AIDS, by 1991 as many as 200,000 will have died. To date, of the approximately 35,000 who have contracted the AIDS virus, over 20,000 have died.[42] Public opinion polls have indicated that AIDS has become the highest priority health concern of the American public, ahead of heart disease and cancer. Society's reaction to AIDS has been that it is mostly a homosexual disease when, in fact, public health officials have expressed great concern over the cross-over into the heterosexual population.

Nationally, AIDS cost over $630 million in 1985 and $1.1 billion in 1986. It is expected to cost the health care system over $8.5 billion in 1991.[43] The costs associated with research and education and other support services rose from $319 million in 1985 to over $542 million in 1986 with a projected increase to $2.3 billion in 1987.[44] Also, from a legal standpoint pertinent to the malpractice crisis, AIDS will be placing additional pressure on the physician regarding patient confidentiality in view of statutory reporting requirements and society's reactions to AIDS victims.

In Florida, the top four life insurance companies have changed their policies requiring all applicants wanting to increase their insurance to a half million dollars to take an AIDS test. Loss of productivity due to AIDS was estimated to be $3.9 billion in 1985 and is anticipated to reach over $66.4 billion in 1991. The cost of AZT for an AIDS victim for one year is estimated at $10,000.

Statistics compiled by San Francisco General Hospital showed the average hospital stay for AIDS patients to be 13 days and the average number of admissions per patient as 1.7. In a study by the Centers for Disease Control, based on 10,000 patients, the lifetime hospital cost to AIDS patients was estimated as $147,000, based on 168 days and average survival time of 392 days and day charge of $878. Still, data is incomplete regarding the estimated true cost of AIDS.

The potential lost income of AIDS victims who normally would have many more productive years adds heavily to the total cost of AIDS. AIDS has the potential of economically depleting the health care system and of seriously affecting the stability of the nation. Confidentiality, health care benefits, and financing are significant issues which physicians will have to deal with in addition to the complexity of the disease itself.

Indigent care ● At the 150% level of poverty, it is estimated that between 1.3 and 1.6 million persons have no health insurance and are ineligible for Medicaid, which currently covers about 536,000 persons. Legislation passed in 1987 providing funding for indigent care should have a positive impact on the physician and hospital community and minimize indigent admissions to acute care facilities because of the availability and accessibility of primary preventive care.

The FMA supported aspects of the indigent care law that call for expansion to all 67 counties of the primary care program delivered through county public health units on a contractual basis with private sector physicians. Implicit in provisions of the law is that the type of organization in which medical services are delivered or the way in which physicians are paid is not important as long as the service is appropriately provided at a reasonable cost to the state and counties paying for care. This was a major switch from legislation proposed last year which would have mandated that indigent care be delivered through prepaid arrangements.

Thus, Florida's indigent health care law of 1987 represents a tremendous opportunity for medicine's private sector to demonstrate that it can effectively help resolve the significant indigent health care problem without being mandated as to how physicians are organized or paid in the provision of services. If the voluntary contractual relationships do not effectively meet the challenge of indigent care, then the medical profession can be assured that future proposals will be based on incentives for the establishment of prepaid/organized arrangements along the lines of HMOs. In that event, failure of the private solo fee-for-service practitioner will have ramifications in the competitive market directed at non-indigents. Further, government and industry, ever conscious of cost containment, will be less sympathetic to voices clamoring about the effectiveness of the solo practitioner in delivering quality care and the need for his continued existence in the competitive marketplace.

Competition and cost containment ● The impact of Medicare, CHAMPUS, managed health care programs, malpractice, AIDS, and indigent care has had a profound effect not only on the physician's practice, but also on the hospital industry. Although the fee-for-service traditional method of health care has dramatically changed over the past several years, the majority of physicians in practice still favor this method of reimbursement and organization. According to the AMA, 89.2% of America's physicians have 50% or more of their practice devoted to fee-for-service.[45] Only 4.9% reported that they devote their entire practice to prepaid care.[46]

With the onslaught of managed health care programs, the majority of physicians have indicated that there is more emphasis upon cost containment which threatens the quality of care. A survey conducted by Equicore Harris indicated that 12% of hospitalized adults said they were released from the hospital prematurely. The increase in physician supply, major emphasis placed upon cost containment, and professional liability insurance have contributed signficantly to the change in the medical practice environment. In Florida the number of physicians increased 30.4% between 1980 and 1985. According to the AMA, there are

26,566 licensed nonfederal physicians in the state.[47]

In 1984 there were 15,484 medical groups in America representing over 81,000 physicians.[48] The average number of doctors in group practices increased from 6.3 per practice in 1969 to over 13.2 in 1986.[49] Group practices can more easily adapt to the multitude of market changes and can offer physicians group discounted insurance coverage as well as the flexibility and ability to negotiate or joint venture with prepaid managed health care plans and hospitals. Group practices are desirable to young physicians because they are not faced with the cost of establishing a practice and can obtain discounted malpractice premiums. Group practices realizing economies of scale can operate in a more economical manner than a solo practitioner.

The average growth rate for group practices was 4.9% between 1969 and 1980. During the 1980-1984 period, the rate increased approximately 9.5%.[50] The most common composition of medical groups is the single specialty followed by the multispecialty and family or general practice. In 1984 there were 724 medical groups in Florida, representing approximately 4.7% of the total United States group practice population and consisting of 5,995 doctors.[51] Utilizing the 9.5% growth rate the total number of group practices in Florida is estimated at 930, composed of well over 7,700 physicians. Group practices do, in fact, earn more per doctor than solo practices and, subsequently, their expense ratios are generally lower. The ratio of patients per doctor is also higher.

In 1986 there were 217 physicians per 100,000 population in Florida as compared to a national average of 195 per 100,000. This is an increase from 1983 of 172 per 100,000 versus the national average of 173 per 100,000.[52] New York, Massachusetts, and California had the highest physician population ratios. Florida physicians averaged $199,000 gross earnings in 1985 as compared to the $182,260 national average.[53] Net income for Florida physicians was $109,170 in 1985 compared to a national average of $102,250.[54] Georgia, Texas, and Michigan reported higher physician earnings in 1985 than Florida. The average income of physicians reached approximately $113,280 in 1985 but, when adjusted for inflation, the average net income has almost remained the same in 1987.[55]

Although physicians income kept up with inflation during 1975-1985, in real terms, net income declined among general and family practitioners, internists, pediatricians and obstetricians/gynecologists.[56] Florida physicians reported over 39.7% of their gross income was used for professional expenses as compared to the national average of 38.1%.[57]

The future income of physicians will depend upon how alternative delivery systems, Medicare, and other "discounted" programs impact their revenues. Physicians, while being pressed to control costs, will have to provide proper treatment in order to avoid a malpractice suit. Quality care and cost containment will be very difficult to balance in lieu of malpractice and cost containment pressures.

Patient visits per week are on the decline. In 1983 in Florida physicians had 117 patients per week which declined in 1986 to 98 visits per week.[58] Nationally, most physicians are experiencing a net decline. Similarly, hospitals are experiencing the effect of competition. According to the Florida Hospital Association, there is four times the national average of investor owned hospitals in Florida. Inpatient admissions decreased from 1.774 million in 1983 to 1.680 million in 1985.[59] The average length of patient stay decreased from 7.4 in 1983 to 6.9 in 1986.[60]

Nationally, total hospital beds decreased by 11.5% from 1974 to 1984 but in Florida there was a 13.7% increase, totaling 7,300.[61] During the period 1974-1985, admissions increased for community hospitals in Florida by 36.2% as compared to a national average of 7.0%.[62] Inpatient days increased 29.5% as opposed to a national average of 5.5%.[63] The average length of stay in community hospitals decreased to 5.4% in Florida and 6.4% nationally.[64]

Florida has not experienced the severity of decline in utilization and average length of stay because Medicare beneficiaries compose approximately 53% of all hospital occupancies and this population segment is steadily rising. The occupancy rate in Florida declined from 73.8% in 1983 to 62.6% in 1985 while the number of hospitals in Florida increased from 254 in 1983 to 268 in 1985.[65]

Multihospital systems, where major joint ventures are occurring that offer additional services, have increased because of the competitiveness of the health care marketplace. Hospitals are also purchasing established primary care physician practices as a means of maintaining hospital occupancy and in assuring long-term stability, preservation and profitability. Physicians can expect more hospitals to entice them into contractual relationships in the future as hospitals react to competition and cost containment demands.

Conclusion • How are physicians to respond to the increased competition as well as emphsis upon cost containment? They will continue to adapt to influences trying to tell them how to practice medicine while at the same time not allowing themselves to compromise the quality of care rendered to patients.

A survey conducted nationally found that the reasons over 50% of patients change doctors were: physician's attitude, availability, location of practice, time spent with the patient, inconvenient office hours, and excessive waiting time. This clearly indicates that society is becoming more service oriented, expecting physicians to provide more services at less cost. Physicians willing to adapt and work around the multitude of forces and demands that are trying to reshape the medical profession will be able

to survive these turbulent times.

Too much emphasis is being placed upon the cost aspect of medical care and not enough upon the advances in medicine which can preserve and maintain quality life for millions of Americans.

Medicare, AIDS, indigent care, malpractice, managed health care programs and industry will continue to have a major impact on the Florida health care system. Society will be the final decision maker in the current health care revolution as to whether medicine, as now organized, will be able to provide all the advanced services that are available, or whether health care rationing will eventually enter the system as part of a new organization in which neither the individual patient nor the medical provider has very much to say about what happens to either one of them.

As Thomas Jefferson so aptly put it two centuries ago: "Time indeed changes manner and notions, and so far we must expect institutions to bend to them." Fearing the changes that are occurring in the health care system prevents one from adapting and preparing for survival. By recognizing these changes and becoming more in tune to the environment, organized medicine can take the leadership role in assisting physicians. Thus, while medicine is in the midst of a revolution, it must yield to some of the pressures for change. But, we must insist upon preserving that which is best in the organization and financing of quality care services for the good of individual patients and the health of the nation.

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A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.

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The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were treated merely with the addition of a diuretic to INDERAL LA.

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LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

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NEW LOW DOSE
INDERAL® LA 60 mg
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Please see next page for brief summary of prescribing information

The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period, the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours, then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered, especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina, where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

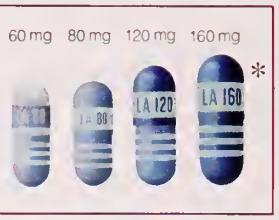
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, vivid dreams, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy and vivid dreams appear dose related.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — *Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

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Medical care as a service industry: some limitations and possibilities for cost containment

Control of the bloat in the costs of medical care is a noble goal that has been avidly embraced in the oratory of politicians, business leaders, consumers and physicians. However, the potential for converting speechmaking to policymaking is severely restricted because most of the causes for the escalation in health care costs stretches beyond the influence of bureaucracy or adminstration.

Health care expenditures increased from $41.9 billion to $425 billion between 1965 and 1985. Fifty-one percent of this increase was due to the general inflation that afflicted the economy during those two decades; eight percent was due to an increase in the number of citizens; and ten percent was accounted for by the increased proportion of people who are 65 years of age or older (these elderly individuals consume four times more health care/capita than do younger persons). Thus sixty-nine percent of the increase in medical care costs can be attributed to factors exogenous to the medical care system itself. Increased access to and utilization of the health care system, more sophisticated technology, and greater complexity of the care given account for the remaining thirty-one percent. Inefficiency and squandering of resources have been blamed for much of this residual thirty-one percent but the volume of hyperbole about overuse and inefficiency exceed the actual amount of waste by a substantial margin. Probably, no more than five percent of health care costs can be attributed to inappropriate usage of the system.

Regulators, insurers, and corporate employers continue to attempt to compress the volume and cost of health care by layering multiple strata of control upon providers and consumers. How much regulatory baggage can they pile on before the system suffocates? The ultimate absurd answer was recently provided in an article about the Russian health care system. Despite the availability of a greater number of physicians per capita than exists in the United States their system is so overweighted with controls that the life expectancy of the average Soviet citizen has fallen seven years during the past twenty years. Other measures of quality of care have also deteriorated. In contrast, during the past quarter century, our health care system has extended the duration of life, from time of birth, over five years for men and women and over 20 years for people who reach maturity. Curtailment of care here could reverse the medical progress we have enjoyed during our recent past.

One reality that makes it very difficult to reduce health care costs in our present system is the intensity of service demanded by sick people. Medicine is a service industry and American service industries have not increased their productivity during the past two decades. Medicine has required both larger numbers of total personnel and more highly trained personnel during this century. In 1900, three out of five health care professionals were MDs. Today, only one of five health care professionals is an MD. In 1900 only 200,000 workers in the health care industry had post-high school professional degrees; today, that number exceeds 2,000,000. Medicine today is the second largest employer among all American industries, and employs nearly 5,000,000 persons.

Most of these people (about 65%) are employed in hospitals and the greatest portion of the increase in health costs has occurred in hospitals. Since 1965 hospital labor costs have grown disproportionately more than labor expenditures in other industries: wage increases for unskilled workers have exceeded those for workers in non-medical occupations; and hospitals have been forced, by the technological advances in medicine, to hire a greater proportion of more highly trained technical workers.

Prior to 1965 unskilled hospital workers were significantly underpaid. Hourly wages were about 75% of those in other, private, non-agricultural industries. The introduction of Medicare in 1966 forced an alteration in hospital wage scales. The greater demand for hospital services enforced increased hiring

of workers. Medicare increased the profitability of hospitals and their ability to increase salaries. Thus, hospital employee salary increases were almost double those of other industries between 1966 and 1969.

The technological evolution of medicine has spurred the development of coteries of new allied health specialists, such as nuclear medicine, cardiac surgery and respiratory therapy technicians. The requirement for specialized training and licensure of these recently-arrived paraprofessionals on the hospital scene has permitted them to receive larger salaries than did other paramedical aides.

The Medicare requirement that the open hospital ward be replaced by semi-private rooms has increased the number of people that are required to service a single hospital wing. Additionally, hospitals are caring for sicker and medically more complex patients which has enhanced the demand for more registered nurses during the past few years. From 1982 to 1984 hospitals increased the numbers of employed, registered nurses from 669,000 to 695,000 but reduced the number of licensed practical nurses from 238,000 to 204,000. Hospitals further reduced its auxiliary nursing personnel from 285,000 to 259,000 in the same period. Thus lesser skilled, lower paid employees are being replaced by much higher paid, more highly trained individuals.

The new Medicare laws and the increased PRO requirements are placing additional demands on hospital medical record and administrative departments.

The changes in medical care that have been wrought during recent history have necessitated a massive expansion in the number of hospital personnel. Hospitals required 178 employees per 100 patients in 1950, 315/100 patients in 1973 and 510/100 patients today. One could argue that this represents progressive inefficiency in the hospital system. However, the rest of the American service sector of the economy is experiencing a parallel demand for greater numbers of technologically more sophisticated people. It is doubtful that the hospital industry has been victimized by a particularly severe epidemic of inefficiency. The hospital sector of the economy is too highly competitive to tolerate an excess of prodigality.

One area of medicine that could be altered by a major increase in productivity is that of the office of the private, primary care physician. There are no data to suggest that doctors are wasting the country's financial resources within their offices; but there is evidence to suggest that individual physicians could be much more productive to themselves and their own net incomes if they more intelligently utilize office personnel.

Physician offices, particularly those of primary care, general internal medicine, and pediatric specialists have suffered a major loss of net income during the past nine years. Their inflation-adjusted, net income (before taxes) has dropped nearly thirty percent even though they are working almost the same number of hours. These practitioners had an overhead of 55% in 1985 - far greater than that of any other specialty. Their median, net income of $78,000 was lower than that of all other groups of physicians. These are the cognitive physicians who have borne the major burden of the cost-containment movement by government during the past 14 years. Because of their low fees, they are required to see more patients per day, employ more personnel, and endure more paperwork. Their patient record-keeping has become more complex and weighty. The incursion of HMOs and PPOs in addition to Medicare, Medicaid and insurance coverage has burdened them with a need for an insurance clerk or specialist within their front office staffs. Pre-admission screening requirements of HMOs and PPOs have added another 5-15 hours per week of office personnel time to their overhead requirements. The competitive environment imposed by PPOs and HMOs, in addition to the Medicare freeze of the past four years, have made it impossible for them to recover their increased costs through higher charges. During the last twenty years their costs have exceeded inflation, yet their fees have not matched the inflation rate. It is estimated that only 75 cents of every dollar of increased overhead can now be recovered by fee increases by a cognitive physician.

Cognitive physicians, unlike hospitals, may have available antidotes to the fiscal claustrophobia impressed by rising costs and dwindling incomes. Cognitive physicians frequently misappropriate their productive time by performing unneccessary chores. They frequently fail to focus on those components of medical care for which they are indispensible - thinking, diagnosing, making therapeutic judgements, and comforting. All other activities are superfluous and, therefore, costly to them. The cognitive physician's greatest overhead expense item is his or her own time. Most physicians try to reduce the non-physician component of their overhead expense. They would more effectively improve their economic well-being by directing their attention to increasing their own productivity. Some physicians dissipate 33 to 50 percent of their patient contact time.

Physician productivity can be enhanced by the assembly and conflation of several time-saving techniques. Patient records should be dictated, never handwritten. Prescription refills should be dictated by the doctor to a paramedical employee who transcribes them and presents them to the physician for review, approval and signature. The results of all laboratory tests and diagnostic procedure reports should be laid out before the physician for review; abnormalities can be highlighted by a nurse or physician assistant. A major share of the data collection process by which we make decisions - such as the patient's disease course since the last visit, the medication compliance and

adverse reaction history, new complaints, and special but lingering concerns can be recorded by a bright paramedic or nurse. The physician then can embellish the data recorder's comments with specific, more deeply probing questions. Routine phone calls should never interrupt the patient care schedule; such interruptions distort the physician's focus and thought processes and absorb time that could be more productively used.

The aggressive, successful physician who has managed to increase his/her practice so that he/she is "too busy" should consider recruiting a physician's assistant or nurse practitioner to the practice rather than hiring another doctor. Immediately the non-MD assistant can increase productivity fifty percent at a cost to the hiring practitioner of less than one-half to one-third the cost of enlisting the services of a new doctor. These specially trained individuals can perform and dictate the history and physical of the patients, review diagnostic test results and identify abnormalities that require the physician's attention, handle many routine telephone calls and questions, and educate patients about their disease and treatment. Properly used, such persons can increase the amount of time that the doctor spends doing what the patient desires - telling the patient about the disease with which he or she is afflicted, the outcome to be expected, the risks and rewards of the medicines to be given, and the solace that only a doctor can impact. Other physician duties of the cognitive physician are meaningless and should be assigned to other, competent people.

Thus, the recognition of the doctor's time as the most expensive overhead item is the prime means by which cognitive physicians can reduce their costs, halt the decline in their net income and increase their opportunity for economic survival.

The adaptation of these efficiency measures can provide the cognitive physician with some temporary respite from the current, cachectic trajectory of net practice income. Nevertheless, these measures are temporizing. Once adapted, the doctor will rise to an efficiency plateau that cannot be superceded by today's medical managerial technology. Economically aggressive physicians might then consider assembling a larger cluster of physicians to share the overhead costs of conducting a private practice. Physicians, who lack entrepreneurial gusto, might also consider joining a multispecialty, private, group practice. Such doctors can enhance practice income by as much as 25% by joining a group.

The fever for cost containment will persist into the indefinite future. Unfortunately, the potential for shrinkage is slight because medicine is so dependent upon people to fulfill its mission of caring for the ill. Unless some genius discovers a method of dramatically multiplying the efficiency of human beings within the service industries, attempts to shave the costs of medical care will either fail or will succeed in paring the system so severely that the quality of the medical care system will decline.

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Daytona Beach

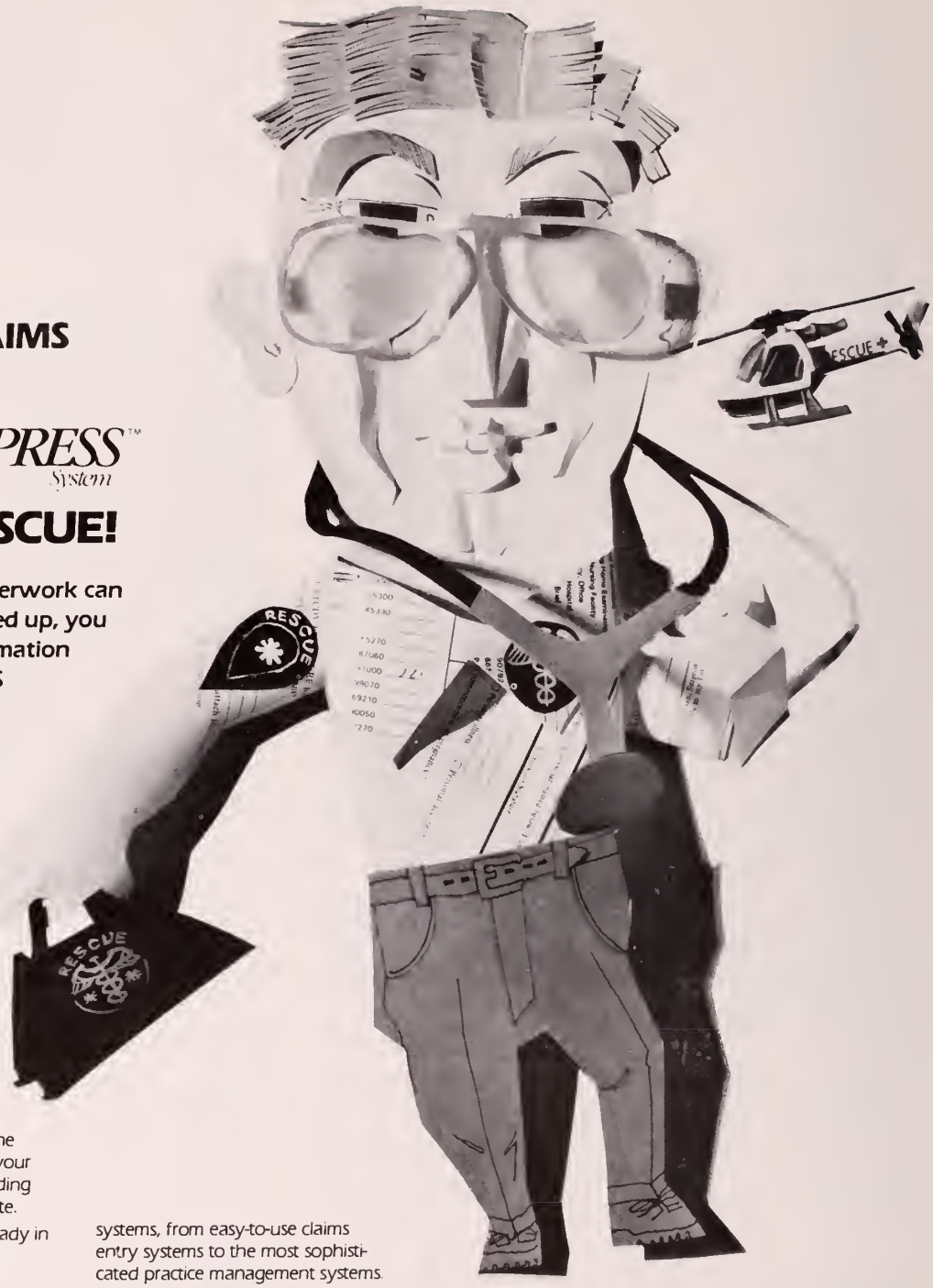
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Foods that may help reduce the risk of gastrointestinal and respiratory tract cancer are cabbage, broccoli, brussels sprouts, kohlrabi, cauliflower.

Fruits, vegetables and whole-grain cereals such as oatmeal, bran and wheat may help lower the risk of colorectal cancer.



Foods high in fats, salt- or nitrite-cured foods such as ham, and fish and types of sausages smoked by traditional methods should be eaten in moderation.

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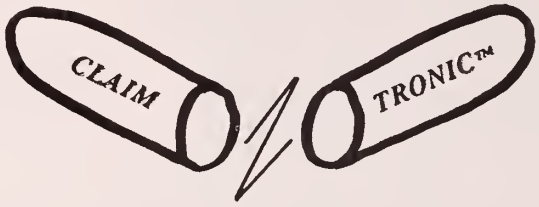
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NOTES & NEWS

All Children's Hospital funds endowed chair in pediatrics at USF

The establishment of the $1 million Andrew and Ann Hines Endowed Chair in Pediatrics at the University of South Florida was announced jointly by USF President John Lott Brown and President of All Children's Hospital Dennis Sexton.

The announcement was made at a reception hosted by the University and the hospital to honor Dr. Robert Good, professor of pediatrics and USF chairman of pediatrics at All Children's Hospital in recognition of his most recent award, the Howland Medal. The medal is presented annually by the American Pediatric Society for distinguished service to pediatrics.

The chair is funded by a $600,000 gift from All Children's Hospital Foundation to be matched by $400,000 in state funds to create the $1 million endowment. It will be established in the College of Medicine's department of pediatrics at the hospital, and be occupied by an eminent scholar in pediatrics.

Andrew Hines, chairman of Florida Progress, Inc., and his wife are former members of the hospital's Board of Trustees. He has also been involved in private fundraising projects at USF, including the Endowed Chair in Marine Science.

"I couldn't ask for a nicer welcome to the Tampa Bay community than this gift," said Vice President for Health Science Ronald P. Kaufman, who came to USF from George Washington University on September 1. "It clearly indicates the ongoing nature of St. Petersburg's support for the College of Medicine and our program."

"The creation of the first chair in Pediatrics for USF at All Children's Hospital further establishes the university's and our commitment to excellence in pediatric care for the entire Tampa Bay area," said Dennis Sexton. "It is also a tribute from the many friends of Ann and Andy Hines for their work on behalf of our hospital and for their contributions to our community."

President Brown will appoint a search committee consisting of members from the university and the hospital.

The Hines Chair brings the total of USF's endowed chairs to 28. Fourteen are established in the College of Medicine.

Robert A. Good, M.D., Ph.D., University of South Florida College of Medicine and Chairperson and Professor of Pediatrics at All Children's Hospital in St. Petersburg received the John Howland Medal on April 29 during the annual meeting of the American Pediatric Society in Anaheim, CA.

This award, which is the Society's most prestigious, was given for distinguished service to pediatrics and is presented annually to the physician who has advanced the field of pediatrics through a career of outstanding achievements. Dr. Good, pediatrician, teacher, researcher and leader in the field of immunology and cellular engineering is the 1987 recipient.

"Our organization, which will celebrate its centennial next year, is a moving force in pediatric education and research promoting the health of children," said Dr. Audrey Brown, permanent secretary of the Society. "The winners of the Howland Medal have made contributions to medical science that reach far beyond pediatrics."

First presented in 1953, the award is named for one of the most prominent pediatricians of the century.

Management education program scholarships to be awarded

The American Academy of Medical Directors (AAMD) will award two scholarship worth $3,000.00 each to physicians to attend management education programs. The scholarships are awarded annually for physicians who are employed by health care organizations that provide service in areas that are medically underserved or that rely predominantly on public or charitable funding.

The program's intent is to promote management development and training within organizations that do not typically have funds for this purpose available for their physician managers. According to AAMD's president, Robert B. Klint, M.D., often this is where the need is greatest. "We believe that there are many physicians in managerial positions within areas of public need, who try to do a good job with little money. With the opportunity to learn and develop good management skills, these dedicated physicians can help improve the effectiveness and efficiency of their organizations and the health care services they deliver."

Each scholarship includes tuition and per diem for three weeks of management training at programs designated by the AAMD. Applicants must submit a letter of intent by January 15, 1988, outlining the following specifics:

- Demonstrate that a need for the scholarship does exist because funding for management training or education is not available within the organization.
- Indicate how the training will be beneficial to the physician manager as well as the organization.
- Demonstrate that the organization is predominantly or entirely supported by public or charitable funds (i.e., indicate percentage of total income received from federal, state or charitable sources.)

To be considered as a recipient of a scholarship, the applicant must be employed by an organization that is a government agency or has qualified for tax exemption under Section 501(c)(3) of the U.S. Internal Revenue Code and is not a private foundation as defined under Section 509(a).

The AAMD will select final candidates for review by January 29, 1988, and will request all finalists to submit a detailed proposal on or before February 19, 1988. Both scholarships will be awarded by the AAMD in early March.

The AAMD is the national professional and educational association for all physicians who have an interest or responsibilities in health care management. It is a recognized specialty society of the American Medical Association, representing physicians in management within group practices, hospitals, health maintenance organizations, academic and government institutions, and private industry.

DEAN'S MESSAGE

Denominators of progress

Two new significant appointments have been made at the University of Florida Health Science Center.

On July 1, 1987, Mr. Paul E. Metts became the Executive Vice President of Shands Hospital, Inc., succeeding Mr. John E. Ives who assumed a similar position at St. Luke's Episcopal Hospital in Houston, Texas. Mr. Metts brings to the position a wealth of experience in hospital administration and economics. A native of Pittsburgh, Pennsylvania, he received his undergraduate education at the University of South Florida with a major in accounting. His graduate degree in hospital and health care administration was obtained from the University of Minnesota.

As a certified public accountant, Mr. Metts was with Ernst & Ernst for several years before joining the Dormavac Corporation as a corporate officer. In 1977, he became the Director of Administrative Services of Shands Hospital and successively Vice President for Administration and Associate Executive Vice President.

In addition, he currently serves as Chairman of the Florida Institute of Certified Public Accountants' Health Care Industry Committee and Chairman of the Management, Accounting and Finance Committee of the the Hospital Financial Management Association. Other activities include service on the Board of Directors of the University Hospital Consortium, Inc., Barnett Bank of Gainesville, Shands Hospital, University Hospital in Jacksonville, University of Florida Foundation, and the United Negro College Fund.

It is clear that he will give Shands Hospital continued leadership in these challenging times for the health care industry.

Byron J. Masterson, M.D., will join the faculty of the College of Medicine on November 1, 1987, as the fourth chairman of the Department of Obstetrics and Gynecology. Currently, he holds a similar position at the University of Louisville School of Medicine.

Born and educated in Missouri, he received his degree in medicine at Washington University, St. Louis, and his residency training at the University of Kansas. Following his basic residency, he was a Fellow in Gynecology at the M.D. Anderson Hospital and Tumor Institute in Houston, Texas. After military service, Dr. Masterson was in private practice in Kansas City, Missouri, for nine years before joining the full-time faculty at the University of Kansas Medical Center, Kansas City. He is board-certified by the American Board of Obstetrics and Gynecology, American Board of Gynecologic Oncology, and the American Board of Laser Surgery. In addition, he holds numerous professional awards and is active in several professional organizations.

The contributions by Dr. Masterson to medical knowledge include seven books. His *Manual of Gynecologic Surgery* is in its second edition. As an author of over sixty journal articles, he has made significant contributions to the treatment of gynecologic cancer. The Masterson surgical clamp and the Masterson endometrial diagnostic device were invented and patented by him.

Dr. Masterson will be the academic pacesetter for obstetrics and gynecology at the University of Florida College of Medicine.

Florida medicine is fortunate to have Paul E. Metts as an ally and Byron J. Masterson, M.D., as a colleague.

"People are the common denominator of progress."
John Kenneth Galbraith - 1964

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ENCORES!

S.O.A.P. — To clean the image of the American doctor

S. WHAT THEY TELL US

1906 - In the ninety-four page preface of George Bernard Shaw's play, *The Doctor's Dilemma,* he devotes himself to depicting the image of the then present day doctor. Excerpts: "I do not know a single thoughtful and well informed person who does not feel that the tragedy of illness at present is that it delivers you helplessly into the hands of a profession which you deeply mistrust." "Doctors are just like other Englishmen: Most of them have no honor and no conscience:-" "On the other hand, when a doctor is in the dock, or is the defendant in an action for malpractice, he has to struggle against the inevitable result of his former pretenses to infinite knowledge and unerring skill." "The test to which all methods of treatment are finally brought is whether they are lucrative to doctors or not." "What the public wants, therefore, is a cheap, magic charm to prevent, and a cheap pill or potion to cure all disease."

1954 - The year I entered private practice. It is my remembrance that the AMA was thought of as a wealthy influential lobby out to devastate any opposition to the advancement of the medical profession. Doctors as a group were beginning to be mistrusted. One's own doctor generally was placed on a pedestal. He was a good guy, kind and trustworthy.

1987 - There has been a gradual deterioration. We are thought of as greedy. We are heartless. We are cold. We will not talk to or listen to the patient. Medical technology has made tremendous strides, yet our image was plummeted.

O. WHAT WE SEE

1906 - Shaw saw the doctor this way: "Anyone who has known doctors well enough to hear medical shop talked without reserve knows that they are full of stories about each other's blunders and errors, and that the theory of their omniscience and omnipotence no more holds good among themselves than it did with Moliere and Napoleon."

"The only evidence that can decide a case of malpractice is expert evidence; that is, the evidence of other doctors; and every doctor will allow a colleague to decimate a whole countryside sooner than violate the bond of professional etiquette by giving him away."

1960 - A New Smyrna Beach general practitioner referred an elderly patient to an orthopedic surgeon in Orlando, Florida, whose treatment caused a disastrous result. Both the referring physician and treating physician were sued. A Daytona Beach physician testified against them. In this geographic area this was a milestone. We were appalled.

1987 - Malpractice suits bring enormous awards. Insurance premiums in southern Florida are staggering. The news media lashes out at the high costs of medical care.

A. ASSESSMENT

How do we correct our tarnished image and release ourselves from the continual threat of litigation? I envision that after the turn of the century medical schools will become Medical Seminaries. Young men and women dealing with aspects of illness will have a dual vocation and, like their Monastic counterpart, will receive minimal or no stipend. They will spend their entire working life, 24 hours a day, at the clinic/hospital complex. The physician would then be a shepherd caring for his flock.

P. PLANS

1906 - George Bernard Shaw: "The social solution for the medical problem then, depends on that large, slowly advancing, petishly resisted integration of society called generally Socialism. Until the medical profession becomes a body of men trained and paid by the country to keep the country in health, it will remain what it is at present: a conspiracy to exploit popular credulity and human suffering." "The theory that every individual alive is of infinite value is legislatively impracticable."

1967 - Medicare USA.

1987 - I believe a "study, work and heal" motto can be adopted under a modified work plan. I suggest:

1. I go to work each morning knowing that the purpose of my being is to help my patients. I must pay my bills and support my family, but really, that is not my reason for getting up.
2. In the course of my work-day I will be burdened by ignorance, by ingratitude, by malingering, by addiction, by being used, but I will treat these all in my most professional manner.
3. I will not push off on my nurse the task of answering patients' calls that I know are better answered by me. I can find the time.
4. I will personally, with patience, explain the

dangers and complications of surgical and medical procedures and drug treatment.
5. If I feel incompetent in diagnosing or treating a patient, I will seek competent consultation.
6. Even under difficult and trying circumstances I will view my patient as an equal and treat him accordingly.
7. I will be humble, although I know I am doing some of the most important work done on earth. I am thankful that I have the talent and training to do it.
8. I will re-dedicate myself daily. I don't give a damn if I die poor.

Russell Welsh, M.D.
New Smyrna Beach

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Malpractice — Here's what really happens

Malpractice is a deviation from standard medical care that results in an injury. In actual practice here is what happens.

Anatomay of a malpractice case ● The patient suffers a bad result that may be produced by a physician's negligence. But most often, the injury is an unpredictable and unpreventable event. When it happens, physicians and nurses may back away from the patient almost as soon as they realize something untoward has occurred. Reasons for withdrawing are complicated and are probably related to professional pride, the psychiatric defenses of avoidance or denial, or even guilt that something, anything, might have been done differently. The net result of this "aloofness" is to produce anger in the patient and raise suspicions that, indeed, something the physician did nor didn't do caused the mishap. At some point in this process, the victim/patient, or a surrogate, seeks a lawyer.

The lawyer, after listening to the patient/victim's complaints, can elect not to proceed. Often, however, further facts need to be obtained to appreciate whether there are reasons to proceed. Frequently, this takes the form of a formal inquiry to the hospital and/or the doctor to supply medical records. This request produces fear and anger among potential defendants. If these emotions are not carefully checked, the hospital and/or doctor's response may well fuel the already smoldering situation.

The next step is, of course, filing a formal complaint with the court, i.e. a suit. It should be pointed out that these papers often contain allegations of the most heinous sort. The doctor and/or hospital are accused of willfully, almost gleefully, causing bodily harm, mental anguish, and acts almost too hideous to mention. Damages are sought in amounts that rival the budgets of some developing third world nations. Clearly, written charges of medical and moral ineptitude fan the flames of anger and resentment even further. The battle is joined!

A next step in this process is to discover what each side knows about the contended issue. This involves obtaining answers under oath to questions drawn up by the plaintiff's lawyer from everyone named in the suit. Since all parties suspect that the plaintiff's lawyers are "fishing", you can bet the answers are not terribly helpful. At this point, there may also be review of the medical facts by outside "experts" since nowhere is there anything written called, "Standards of Medical Care". You would think that somewhere in all the dusty tomes of the medical library, there would be a large block of granite on which are carved the ten commandments of medicine, called "Standards of Care", regularly updated and containing the basic stuff of medicine. On the contrary, nobody in medicine agrees just what is standard care. Even medical educators, charged with the responsibility of teaching new doctors what they need to know, inform us that there is no consensus about what minimal knowledge might be. Thus, if the issue is whether some standard of care has been breached, opinions must be gathered from people regarded as experts by the court. This results in some pretty interesting material.

The court takes a liberal view of who is an expert. By and large, an expert is any person with a medical degree willing to appear in court. Often, they have training and experience in the general area under contention, but not necessarily. Organized medicine frowns on this activity. Furthermore, real experts are often too busy taking care of patients to be available. In practice, plaintiff's lawyers frequently try to depict the other side's witnesses as close personal friends of the defendant. Defendant's lawyers look at plaintiff's witnesses are "hired guns" or, even worse, as "prostitutes" or "turncoats" from the medical profession. There is often one, or more insurance companies involved. These companies send representatives, and sometimes lawyers, to all activities. Their goal is to cut financial losses. The whole activity is filled with distrust, fear, and anger — these emotions are fuel feeding the entire conflagration.

The proceedings grind on slowly and consume enormous time and effort. The physician loses time, sleep, and self confidence. The patient/victim loses time, sleep and trust. Medical science doesn't advance either, as no specific clinical messages are sent except that more defensive medicine needs to be practiced.

Financial awards — A vicious cycle ● The most com-

mon result is a nonfinancial settlement or a financial settlement short of the original damages sought. Often, settlement exonerates the health care providers. Such settlements, however, are frequently for considerable sums. Occasionally, money may be obtained directly from the physician's pocket. More often, pools of insurance money are tapped. This presents an interesting conundrum. Suits may be joined against several individuals or institutions, but pursuit is most active against those with the best insurance coverage. The reader should immediately realize that this represents a cruel paradox. The more insurance carried, the more liable is aggressive assault in a malpractice action. Too little insurance coverage, and the "doc" is vulnerable to personal loss. It is, indeed, a tough world.

In the end, most participants are less than completely satisfied. Certainly the doctor has lost resources and pride. The victim/patient still has the bad medical result but may be able to afford more physical relief or better care. Insurance companies have lost money, but will raise their rates to cover this loss. The lawyers go on to other pursuits.

The effect on medicine ● Medicine, in general has also been diminished because of the glut of malpractice actions in recent years. Defensive medicine has become a buzz word among practitioners. Many tests and procedures are being performed for unclear medical indications, but which are thought to prevent unusual or unlikely complications. Sometimes these tests are done to cover a potentially vulnerable fanny. Medical care has not been upgraded. The opinions of experts do not get compiled in some sort of "master text" to advance medicine. They just get buried in depositions or in dusty insurance company files. (Until publication of *Medical Malpractice Prevention* began!)

This essay is clearly biased, since I am a practicing physician. However, I can't help but remark on the mismatch between avowed philosophies by the medical and legal professions and what is actual practice. Physicians go on practicing medicine and lawyers will do law. Costs for both services escalate. It is a no-win situation that ought to be upset.

John W. Scanlon, M.D.
Director of Neonatology
Columbia Hospital for Women
Professor of Pediatrics
Georgetown University School of Medicine
Washington, D.C.

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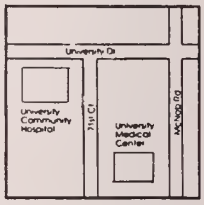
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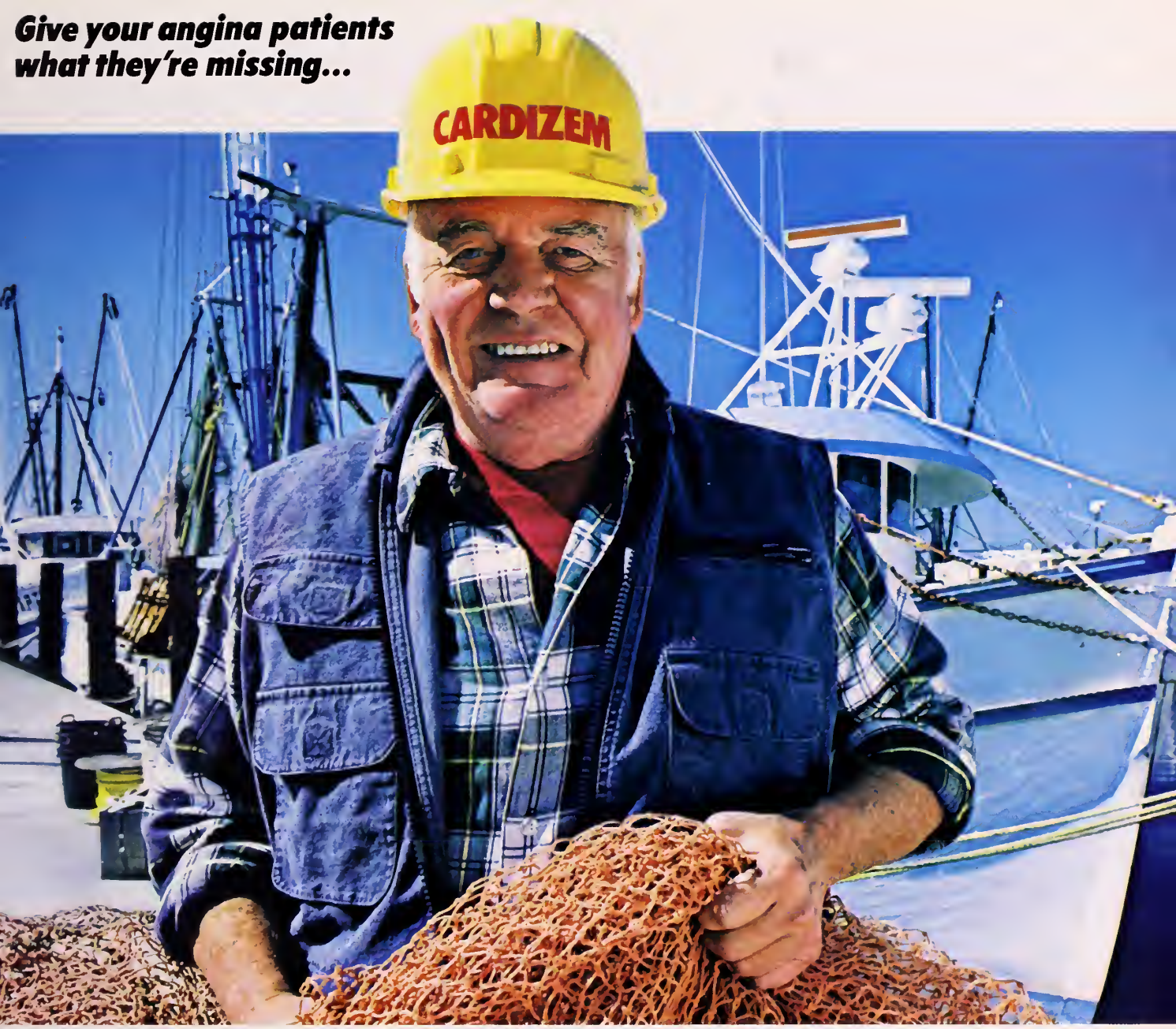
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WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 9/86*

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References: ***1.*** *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347.* ***2.*** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159.* ***3.*** *Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687.* ***4.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***5.*** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.*

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Book Review Editor—F. Norman Vickers, M.D.

Clinical Electrocardiography, A Primary Care Approach

by Ken Grauer, M.D., and R. Whitney Curry Jr., M.D.
544 pages, price: $24.95. Medical Economic Books, Oradell, N.J. 1987

Numerous books on clinical electrocardiography have been published in the past and are being published currently and a new one should have some unique approach. The authors, Dr. Grauer and Dr. Curry, of the Department of Health and Family Medicine, College of Medicine, University of Florida, have endeavored to publish this book on Clinical Electrocardiography as a primary care approach aimed at family physicians, primary care physicians, general practitioners and family practitioners. The book is in four parts. Part I introduces the basic concepts of electrocardiography and how to look at EKGs and interpret a simple or normal EKG. Part II addresses various pathological conditions including the S-T segment, interventricular conduction defects, myocardial infarction, and left ventricular hypertrophy. Part III reviews various exercises and EKG interpretations with the aim of increasing the reviewer's confidence in the ability to interpret these. Part IV offers references and a key to abbreviations and the list of important figures and table and handy reference guide and an index.

I believe the book to be generally accurate and well presented in an organized manner. I found it somewhat detracting when reviewing the various figures because they either had some type of computer drawn system or some strange system that was reproducing the P, QRS, and T complex in that it never looked like a normal QRS complex except in instances where they were actually reproducing copies of true or actual EKGs. The figures depicting heart drawings in the conduction system were also difficult for me to analyze because of the same problem and that is, an inherent undulation or uneveness to the depiction of the conduction system and heart modalities. I assume that this must have been printed in some special way or in using a computer but I could not be certain of this. At any rate, it was somewhat detracting.

On the other hand, the text was accurate and presented concisely and clearly and it had obviously been thoroughly reviewed. I found virtually no mistakes or typographical errors.

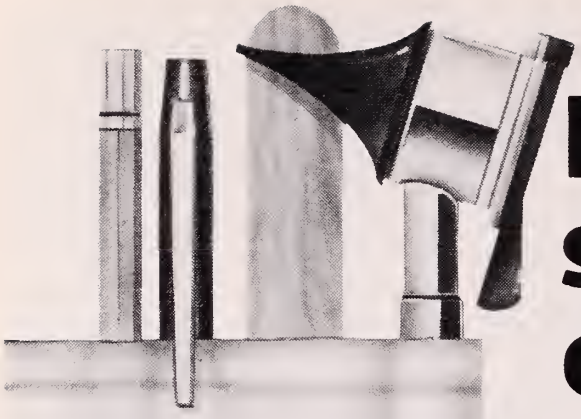
Under the section called Clinical Applications which consist of descriptions of the abnormalities of the various segments of the EKG, the authors present a description and a typical example or a clinical discussion of the "problem" with an interpretation of various figures. I found that I had to constantly refer back to the figure because the description interpretation may be several pages from the figure and the interpretation. If at all possible, it would have been much easier to review these and compare the actual figures and sample EKGs with the description and interpretation if they were either adjacent or as close to the actual figure as possible. Again, this was somewhat detracting and interfered with concentration. This is especially a problem beginning on page 375 which begins the review exercises and EKG interpretation. At this point, several figures were listed showing, for example, Figures A-1 through A-6. This was followed then by the interpretation of the text so that it was quite difficult, at least for me, to review the EKG compared to the text. It would have been much more helpful to have condensed the EKG unto one page and put the text on the second page if this had been at all possible.

Generally speaking, I believe the authors have done an excellent job of providing a text on Clinical Electrocardiography for the primary care physician and this was their important aim. The complaints that I have listed are not minor ones as far as the accuracy and textural content is concerned. I think that they are to be congratulated for the yeoman's effort in

providing a complete and accurate text. The book could have been much much better had it been presented in a little more organized fashion, however, so that a novice reader would not have to spend a large amount of time comparing text and figures.

Mark V. Barrow, M.D.
Gainesville


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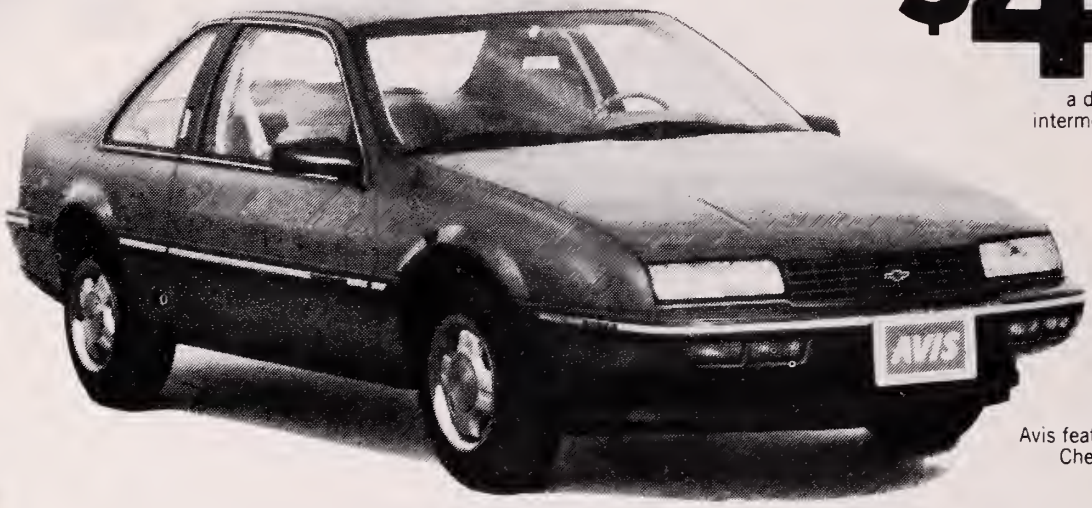
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Auxiliary Liason Editor — Mrs. Walter (Isabella) Laude

The power of love and commitment

As I reflect over this past year I am filled with pride from the accomplishments of the Auxiliary in each county of the state. Even with the change of dates for our meetings and the way we bill our members, those problems were worked out so we could proceed forward to achieve our goals.

Contributions to AMA-ERF were never greater in a shorter length of time. International Health reached its goal in tribute to Terry Carver, its chairman. Membership increased its total Federation dues receiving an award at the AMA Auxiliary Convention. We still have work to do in this area because we need all the spouses to belong even if they work outside the home. We need their expertise to be totally united with the FMA to solve the greatest problem in the health care crisis this state has ever faced . . . professional liability and unavailable health care. Any one of us alone may not be able to solve the problem but the strength of justice, fairness and standing united together is the key to change the course of history and right the wrong that is trying to destroy the best health care system in the world.

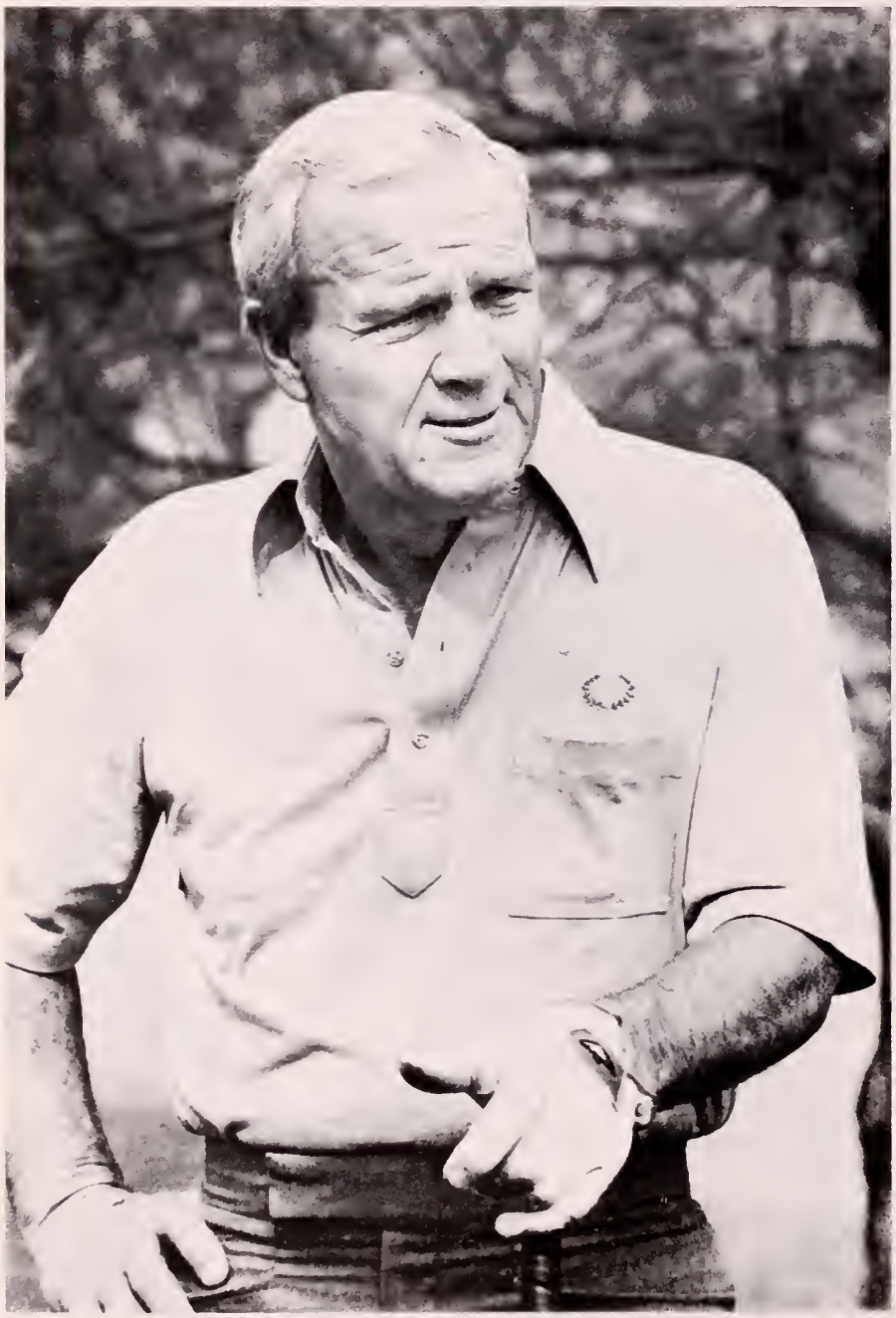
So solid is the evidence of the problem that we all need to speak out and bring the truth to the people. With all the members of the FMA and FMA Auxiliary, family, friends and patients, we can actively challenge the unfairly mandated laws that have brought the liability crisis to the breaking point.

The FMA has worked against all odds, timing and frustration to come up with the greatest piece of legislation in many years to present during the Special Session - the MICA plan - and a Florida Constitutional Amendment to place a $100,000 cap on noneconomic damages. We must all be united and work together if we are to be successful. Compromise is out of the question when it comes to human life.

I would rather fail trying for justice than to be the biggest successful nothing human being in the world. With our love and commitment we will succeed! I pledge my commitment to this goal no matter how long it takes! Do I have your pledge?

Mrs. V.A. (Susan) Marks
President
Florida Medical Association Auxiliary

'You Should Hear What You're Missing'



Legendary golfer Arnold Palmer, who personally overcame a hearing problem, urges others to benefit from available hearing help:

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You know, nearly 20 million Americans with hearing problems needlessly miss life's precious sounds. Why needlessly? Because virtually all of them can *now* be helped—medically, surgically, or like me, with hearing aids.

If you suspect a hearing loss, or thought nothing could be done about it, ask your family doctor who can guide you. Thanks to significant advances in the hearing field, there are many hearing health care professionals who can help you.

So if you or someone you love doesn't hear well, arrange for a hearing test today. For hearing help information, call toll-free Hearing HelpLine at 800/EAR WELL.

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Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

OCTOBER

Problems of Adolescence: The Reaction to Stress, October 2, New World Landing, Pensacola. Contact: Phyllis Connerly 904-478-4460.

The Friary's Sixth Annual Professional & Chemical Dependency Seminar, October 2, Pensacola Beach. Contact: Brunie Emmanuel, (904) 932-9375.

Professional Liability, The Physicians Role, October 3, St. Petersburg, Edward White Hospital. Contact: Henry Mela Jr., M.D., 813-323-1111, ext. 1331.

Emerging Trends in Critical Care—1987, October 7-9, Crowne Plaza Hotel, Orlando. Contact: Rick Mace, (305) 897-1575.

After the Golden Hour, October 9, Pensacola, Hilton Hotel. Contact: Robert Rubey, M.D., 1201 W. Morero St., Pensacola 32501. 904-434-4819.

Workshop on Clinical Hypnosis, October 9-11, Orlando. Contact: Charles B. Mutter, M.D., 1440 NW 14th Avenue, Miami 33125. 305-547-2000.

Medical Risk Management, TBA, Miami. Contact: Ronna Davis, P.O. 12099, Tallahassee, FL 32317. (904) 385-4935.

Cardiopulmonary Update, October 9-11, Marriott at Sawgrass, Ponte Vedra Beach. Contact: Alberta Hipps, 1800 Barrs St., Jacksonville 32203. (904) 387-7563.

Emotional and Behavioral Addiction October 9-11, Lake Buena Vista, Hotel Royal Plaza. Contact: Alan Matez, 8950 Villa La Jolla Dr., Suite 2224, La Jolla, CA 92037-1710.

Concepts in Medical Care October 17-18, Omni Jacksonville Hotel. Contact: Hortencia Espino, M.D., 800 Lomax St., Suite 101, Jacksonville 32204, (904) 355-7778.

Lipid Disorders 1987: Issues and Answers, October 18. Miami Airport Hilton. Contact: Ronald Golderg, M.D., 305-547-6504.

All America's Health '87, October 15-18, Curtis Hixon Convention Center, USF College of Medicine. Contact: P.J. Bouis Jr., M.D. (813) 974-4296.

International Symposium on Gynecologic Oncology, Surgery and Urology, October 18-23, Japan. Contact: Patti Mundy, (305) 549-6944.

Thirteenth Annual Panamerican Seminar, October 19-23, Mt. Sinai Medical Center, Miami Beach. Contact: Mt. Sinai Medical Center, Attn: CME Coordinator, 4300 Alton Road, Miami Beach 33140. (305) 674-2311.

Magnetic Resonance Imaging, October 19-23, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D., (813) 974-2538.

13th Annual Panamerican Medical Seminar October 19-23. Mt. Sinai Medical Center. Contact: Federico Justiniani, M.D., 4300 Alton Road, Miami 33140. 305-674-2311.

Fall 1987 Family Practice Review, October 19-23, Peabody Hotel, Orlando. Contact: Grace Wagner, JHMHC J-233, Gainesville 32610. (904) 392-4321.

Risk Management Workshop Miami Airport Hilton, October 23. Contact: Charles A. Dunn, M.D., 1627 Rogero Road, Jacksonville, FL 32211-4866. 904-743-6304.

A Case Study Approach to Risk Management and Malpractice, October 23, Sheraton, Bal Harbour. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

Thirteenth Annual Gulf Coast Internal Medicine Conference, October 23-24, Pensacola Hilton, Pensacola. Contact: Dr. Garth Grove at (904) 474-7101.

45th Regional Family Practice Weekend, Miami, October 23-25. Miami Airport Hilton. Contact: Charles A. Dunn, M.D., 1627 Rogero Road, Jacksonville 32211-4866, 904-743-6304.

Current Concepts in Wound Healing and Photography for Cutaneous Surgery, October 27. Boca Community Hospital. Contact: Larry Garland, M.D., Dept. of Derm., University of Miami, P.O. Box 016960, Miami 33101, (305) 547-4477.

Current Concepts, October 27. Boca Community Hospital. Contact: Larry D. Garland,, M.D., P.O. Box 016960, Miami 33101, 305-547-4477.

Lipid Disorders 1987 October 28. Miami Airport Hilton Hotel. Contact: University of Miami, Division of CME (D23-3), P.O. Box 016960, Miami 33101.

Twenty-eighth Workshop in Electrocardiography, October 28-31, Sheraton Sand Key, Clearwater Beach. Contact: Henry Marriott, M.D., (813) 894-0790.

Fifth Annual Advanced Neuroradiology, October 29-31, Marriott Orlando World Center, Orlando. Contact: Charleen Krissman, (813) 974-2538.

A Case Study Approach to Risk Management and Malpractice, October 31, Contemporary Hotel in Walt Disney World. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

Medical Risk Management, TBA, Tampa. Contact: Ronna Davis, P.O. Box 12099, Tallahassee, FL 32317. (904) 385-4935.

NOVEMBER

Internal Medicine Update '87 November 1-6. The Colony Beach Resort. Contact: Murray Grossman, M.D., 315-473-4606.

Primary Care Update: Seventy-second Scientific Assembly, November 2-5, Diplomat Hotel, Hollywood. Contact: Ray W. Gifor Jr., M.D., (608) 257-6781.

Thirteenth Annual Obstetrics and Gynecology Review Course, November 3-11, Doral Hotel on the Ocean, Miami. Contact: Patti Mundy. (305) 549-6944.

Advanced Applied Ultrasound in Obstetrics, November 5-7, Bowman Gray School of Medicine, Naples. Contact: Regsitrar, Ultrasound Center, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, N.C. 27103 or call: (919) 748-4504.

Neonatal & Pediatric Respiratory Disease Conference, Sheraton Sand Key, Clearwater Beach. Contact: R. Lawrence Siegel, M.D. (813) 972-3131.

Procedural Skills for Primary Care Physicians, November 7-8, Sheraton Hotel, Dania, FL. Contact: Donald A. Berman, M.D. (305) 989-6650.

ACLS Provider Course, November 7-8, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

American Heart Association ACLS Instructor Course, November 7-8, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

Advances in Perinatology, November 8-14, St. Thomas, U.S. Virgin Islands. Contact: Eduardo Bancalari, M.D. (305) 547-5808.

Care of the Sick Child, November 11-14, Palace Hotel, Lake Buena Vista. Contact: Colin J. Condron, M.D. (305) 841-5144.

Flexible Sigmoidoscopy in the Diagnosis, November 12-15, Palace Hotel, Lake Buena Vista. Contact: Edward J. Kowalewski, M.D. (212) 517-7520.

Thirteenth Annual Ob/Gyn Pathology Review, November 12-15, Doral Hotel on the Ocean, Miami. Contact: Patti Mundy (305) 549-6944.

Nutrition in Pediatric Practice, November 13, Sheraton Tampa East, Tampa. Contact: Herbert Pomerance, M.D., USF Dept. of Pediatrics, 12901 Bruce B. Downs Blvd., Box 15Ce, Tampa, FL 33612. (813) 974-4214.

The Distal Radioulnar Joint, November 13-14, Orlando. Contact: Paula Scheid, 3025 S. Parker Rd., Suite 65, Aurora, CO 80014. (303) 755-4588.

ACLS Instructor's Course, November 13-15, St. Augustine Technical Center, St. Augustine. Contact: Mrs. Margo Kinsey (904) 824-4401.

The Role of Stress in Medical Disorders, November 14, Marriotts Harbor Beach Resort, Miami. Contact: Division of CME (305) 547-6716.

Flexible Sigmoidoscopy, November 14-15, Sonesta Beach Hotel, Key Biscayne. Contact: John P. Christie, M.D., (305) 687-1367.

All America's Health '87, November 15-18, Curtis Hixon Convention Center, Tampa. Contact: Pierre J. Bouis Jr. M.D., (813) 974-4296.

Series on Diagnostic Parasitology, November 19-21, Devetec Building, Sarasota. Contact: Donald L. Price, Ph.D. (813) 351-1454.

Choices in Cancer Care, November 20-21, Embassy Suites Hotel, Ft. Lauderdale. Contact: Cheryl Barillari (813) 253-0541.

Eleventh Annual Seminar of the Florida Association of Pediatric Tumors, November 19-21, Holiday Inn Crown Plaza, Orlando. Contact: Cindi Butson, P.O. Box 13372, University States, Gainesville, FL 32604. (904) 375-6848.

Perinatal Conference, November 21, 1987. Hilton Hotel, Ft. Walton Beach. Contact: Thomas Moraczewski, M.D. (904) 862-5618.

Small and Large Defects, How I Repair Them, November 24, Boca Community Hospital, Boca Raton. Contact: Larry D. Garland, M.D. (305) 547-6716.

ACLS Provider Course, November 28-29, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

DECEMBER

Clinical Allergy & Immunology for the Practicing Physician, December 3-5, Buena Vista Palace, Lake Buena Vista. Contact: Richard F. Lockey, M.D., (813) 972-7631.

1987 Neuro-Opthalmology Course, December 3-5, Key Biscayne Hotel, Key Biscayne. Contact: Goby Kressly (305) 326-6031.

Innovative and Controversial Strategies in Rehabilitation, December 3-6, Sheraton Bal Harbour, Bal Harbour. Contact: John H. Bowker, M.D. (305) 547-6716.

Diagnosis & Management of Respiratory Diseases, December 4-6, Boca Raton Hotel, Boca Raton. Contact: Karen DeBont, (800) 421-3756.

1987 FINA World Medical Congress, December 5-8, Justus Aquatic Center/Radisson Hotel, Orlando. Contact: Allen Richardson, M.D., (303) 578-4575.

Emergencies in Internal Medicine, December 6-12, St. Thomas, Virgin Islands. Contact: Laurence B. Gardner, M.D. (305) 547-6716.

Medical Risk Management, December 12, TBA, Jacksonville. Contact: Ronna Davis, P.O. Box 12099, Tallahassee, FL 32317. (904) 385-4935.

A Case Study Approach to Risk Management and Malpractice, December 18-19, Sheraton, Bal Harbour. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

JANUARY

Workshop in Clinical Hypnosis, January 14-17, Location to be announced. Contact American Society of Clinical Hypnosis, 2250 East Devon Ave., Suite 336, Des Plaines, IL 60018 (312) 297-3317.

33rd Annual Cardiovascular Seminar, January 15-16, St. Petersburg Hilton, St. Petersburg. Contact: Melissa S. Crater, (813) 867-5000.

Advances in Neurology, January 17-23, South Seas Plantation, Captiva Island, Ft. Myers. Contact: Millie F. Walden (904) 374-6058.

Lipo Injection Technique, January 19, 1988, University of Miami, Miami. Contact: Larry D. Garland, M.D. (305) 547-4477.

20th Annual Postgraduate Seminar in Pediatric and Adult Urology, January 21-23, Doral Hotel On-the-Ocean, Miami Beach. Contact: Victor A. Politano, M.D. (305) 687-1367.

Problem Oriented Approach to Vitreous Surgery, January 25-27, Biscayne Bay Marriott, Key Biscayne. Contact: Karl Olsen, M.D., University of Miami, Dept. of Ophthalmology (305) 326-6031.

Arrhythmias: Interpretation, Diagnosis and Management, January 29-30, Bahia Mar Hotel, Ft. Lauderdale. Contact: Deborah Wilderson 1-800-421-3756.

Vail Conference in Anesthesiology, January 30-February 6, Vail, Colorado. Contact: N.W. Brian Craythorne, M.D. (305) 547-6411.

FEBRUARY

13th Annual Review and Recent Practical Advances in Pathology, February 1-5, Fountainbleu, Miami Beach. Contact: Marie Valdes-Dapena, M.D. (305) 549-6437.

Current Concepts in Cardiovascular Disease, February 1-5, Buena Vista Palace Hotel, Orlando. Contact: Clarence Shub, M.D. (507) 284-2511.

Vail Symposium in Intensive Care, February 6-13, Vail, Colorado. Contact: N.W. Brian Craythorne, M.D. (305) 547-6411.

20th Miami Winter Symposium, February 8-12, Hyatt Regency, Miami. Contact: W.J. Whelan, M.D., University of Miami, Dept. of Biochemistry (305) 547-6265.

Risk Factors for the Development of Skin Cancer and its Treatment, February 9, University of Miami, Miami. Contact: Larry D. Garland, M.D. (305) 547-4477.

Cardiology at Walt Disney World, February 11-14, Contemporary Resort Hotel, Lake Buena Vista. Contact: Scott Greenwood, M.D. (305) 843-1330.

Conference on the Beach, February 15-20, Holiday Inn Surfside, Daytona Beach. Contact: William G. Tomson, M.D. (904) 254-4167.

Reproductive Organs Abnormalities Symposium, February 17-20, Vail, Colorado. Contact: James Ingram, M.D. (813) 974-2088.

Health Care for the Elderly, February 19-20, Radisson Hotel, Orlando. Contact: Eric Pfeiffer, M.D., USF Med. Center (813) 974-4355.

Pediatric Dermatology CME Tour, February 19-March 7, India. Contact: Mr. Frank Martin 1-800-243-5030

Radiology in Seville, February 20-27, Seville, Spain. Contact: Lucy R. Kelley (305) 674-2681.

15th Annual Symposium in Pediatric Nephrology, February 21-25, Sheraton Bal Harbour Hotel, Miami Beach. Contact: Pearl Seidler (305) 549-6726.

Feburary Course in Electrocardiography, February 29-March 2, Marriott Hotel, Boca Raton. Contact: Jules Constant, M.D. Cardiac Study Fund, Box 114, Hiler Branch, Buffalo, NY 14223 (716) 836-5172.

MARCH

20th Teaching Conference in Clinical Cardiology, March 2-5, Sheraton Bal Harbour, Bal Harbour. Contact: Michael S. Gordon, M.D., Ph.D., University of Miami (305) 547-6716.

Wound Dressing/Retinoic Acid March 8, Univ. of Miami, Miami. Contact: Larry D. Garland, M.D., P.O. Box 016960, Miami, FL 33101

Breast Disease Update & Seminar, March 16-18, The Hilton, Lake Buena Vista. Contact: Esther Cohen, M.D. (305) 674-2311.

AIDS: Defining the Process, March 24-26, Building TBA, Daytona Beach. Contact: Halifax Medical Center, Educational Services (904) 254-4169

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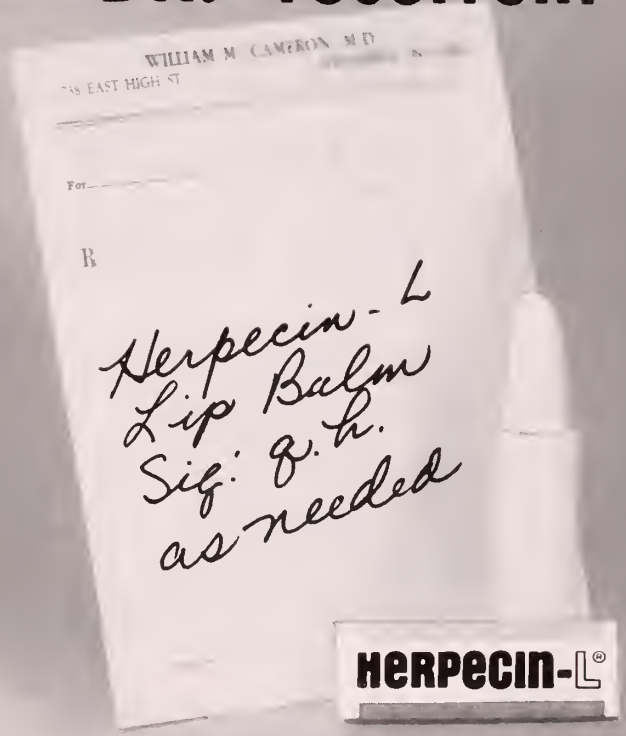
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THE MOUNTAINS ARE BEAUTIFUL AND WEATHER COOL. OB-GYN - If you are a board certified or finishing resident who might be interested in a rewarding professional practice, give Murphy, NC serious consideration. Murphy Medical Center is a modern, seven year old, 50 acute care and 120 long term care bed facility which serves a four county population of 45,000$. Located in the foothills of the Smokey Mountains, Murphy offers the advantage of a small-town lifestyle, with numerous outdoor activities, without the sacrafice of urban advantages. Atlanta or Asheville are under a two hours drive from Murphy. Attractive first year financial guarantee is available. For more information write or call: CEO, Murphy Medical Center, 2002 US Highway 64 East, Murphy, NC 28906, 704-837-8161. EOE.

GASTROENTEROLOGIST-Board Certified for metropolitan community of 200,000 in Texas. Private practice opportunity with hospital support. Position available immediately. Send CV to Maureen Bragg, Summit Health Ltd., 1800 Avenue of the Stars, Suite 1200, Los Angeles, CA 90067. (213) 201-4000.

TEXAS-growing progressive town, 39 bed debt-free Community Hospital, 65 bed debt-free Rest Home, Doctor's Clinic, no "buy-in"—6 figure financials guaranteed, good schools, great climate, G.P., Famly Practice, OB/GYN, General Internist, 1-3 doctors, man/wife team welcome, Friona, Texas. Contact: Hollis Horton (Days) (806) 247-3030, (Nights) (806) 247-3247; or Robert Neelley (Days) (806) 247-2706, (Nights) (806) 247-2542.

RHEUMATOLOGIST, NON-INVASIVE Cardiologist, pediatric surgeon, and obstetrics & gynecology. 40 physician multi-specialty Group in W. Palm Beach, FL seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 2 years. Send CV to Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 N. Olive Ave., W. Palm Beach, FL 33401.

AVAILABLE IMMEDIATELY full or part-time. May have hospital in-patients or out-patient practice only. Large family practice. Partnership available after one year. Excellent salary and fringes. Located Florida's Gulf Coast between Tampa and Fort Meyers. Send CV to: P.O. Box 537, Venice, FL 34285 or call (813) 485-4858.

FLORIDA (Jacksonville)-Clinic based General Pediatrician with special interest in Community Pediatrics and handicapped children. U.S. trained and Board eligible, plus current eligibility for Florida license. Contact P. E. Findlay, M.D., Nemours Children's Clinic, P.O. Box 5720, Jacksonville, FL 32247. Or call collect at (904) 390-3627.

EMERGENCY MEDICAL GROUP, a progressive, physician-owned organization is seeking Full and Part-time Board certified/eligible and Family Practice physicians for openings in Southeast Florida. Competitive salary, paid malpractice insurance, benefits and attractive scheduling. Send CV to Emergency Medical Group, 1400 NW 12th Ave., Miami, FL 33136.

ACTIVE, ESTABLISHED AMBULATORY CARE CENTER. Tallahassee. Seeking Board Certified Family Practice or

Emergency Physician for full-time work. Excellent community. Diverse outdoor recreation, excellent schools and housing values. Superior working environment-no night call. Class "A" malpractice category in "low-risk" area of Florida. 48 hours/week $103,000. Please contact: Douglas Sherman, M.D. or Bill Riddle at Physician Care (904) 386-2266.

FT. LAUDERDALE, MIAMI, Palm Beach. Physicians for family practice centers. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, FL 33317.

BOARD CERTIFIED OR ELIGIBLE DIAGNOSTIC RADIOLOGIST with special interest in breast imaging for women's diagnostic center suburban Miami, FL. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1424, Jacksonville, FL 32203.

INTERNIST NEEDED: An immediate opening exists for an internist, preferably board eligible or certified, in a rural, mountainous area of north central West Virginia with a newly renovated 26 bed hospital located in the town. Nestled in the heart of vacation and recreation areas there is hunting, fishing, a championship golf course and two major ski areas located within an hours driving time of the town. This practice has great potential with a lucrative guarantee and office space and support personnel provided the first year. In addition a 146 bed hoispitla with all major specialties is located within 25 minutes of the practice. Contact or sent your CV with home and office phone numbers to Robert L. Morris, CEO, Tucker County Hospital, Inc., P. O. Box 280, Parsons, W. VA 26280-0280. EEO.

FAMILY PHYSICIAN WITH OB — VERMONT. Lovely community in the heart of ski country with excellent rural health center. Join two physicians. Enjoy salary plus full benefits. Vermont's lifestyle at its best. Send CV to New England Health Search, 63 Forest Avenue, Orono, Maine 04473 or call 207-866-5680.

PHYSICIAN: Internist or Family Practitioner for busy Family Practice in Hallandale. Opportunity for permanent association, will consider financing. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1434, Jacksonville, FL 32203.

MIDLAND, TEXAS: Sudden need due to illnes of a 4th full-time experienced Emergency Physician at 25,000 volume, Level II Emergency Department. ACLS/ATLS required. Prefer board certified/board prepared in EM but will consider others with good experience and credentials. Compensation in excess of $140,000. Contact Chip Klunick, M.D., 915-683-6246 or Paul Best, M.D. 915-367-3589 or 915-685-1558.

SHENANDOAH VALLEY OF VIRGINIA: Shenandoah County Memorial Hospital of Woodstock, Virginia is looking for physicians--OB/GYNs, Family Practice, ENTs, Orthopedic Surgeons, General/Vascular Surgeons--to practice in our expanding community. A 133 bed acute care community hospital, SCMH is located in the beautiful Shenandoah Valley/Blue Ridge Mountain area of Virginia, just 90 minutes west of Washington, D.C. High income potential and LOW MALPRACTICE RATES (see our display ad on page 727 for complete list of rates.) Call the Office of Administration at (703) 459-4021, Ext. 457, or send CV to: Administrator, Shenandoah County Memorial Hospital, P.O. Box 508, Woodstock, Virginia 22664.

TIRED OF HMOs? Conduct your specialty or primary care practice in a traditional setting in a growing community south of Ocala. Demand for all specialties exceeds supply (AMA market profile available). The new Mockingbird Hill Professional Center is now open with lease/purchase option. Opportunity now exists for custom interior design. Lab and x-ray on-site and private ambulatory care center provides a referral base. Only 10 min. drive to HCA hospital. For information call or write Carol Roberts, Care-1, Inc., 1805 S.E. Lake Weir Ave., Ocala, FL 32671 or (904) 351-0789.

ALL SPECIALTIES SOUGHT for various client opportunities throughout the southeastern U.S. Amb. care, HMOs, multi-single specialty groups, partnerships, sold. Needed especially are: IM, FP, EM, DERM, CARD, ENT, ORS, GS. All positions provide excellent financial incentives in attractice/coastal locations. For details call collect (813) 621-7331 or (904) 799-2224 or send CV in confidence to: SPR, Inc., P.O. Box 11337, Tampa, FL 33680.

FAMILY PHYSICIAN: BC or BE for West Palm Beach practice. FL license necessary. Opportunity for future partnership. Call: (305) 967-0234.

BOARD CERTIFIED GENERAL SURGEON, as associate, private practice in Orlando. Send CV, references, photo to Box C-1366, P.O. Box 2411, Jacksonville, FL 32203.

ASSISTANT/ASSOCIATE PROFESSOR position available within the Department of Pediatrics, Division of Immunology/Infectious Disease. M.D. Degree required. In addition, a Master's Degree or Ph.D. in Public Health favorable and post-graduate training in infectious diseases and immunology with emphasis on area of virology and hospital epidemiology; Interest in teaching, patient care, and research. Duties included: teaching of medical students, professional service in the form of attending on rounds and serve as hospital epidemiologist for cchildren; participate in lectures for Phase A, B and C. Recruiting Deadline: November 2, 1987. Anticipated start date: January 1, 1988. Interested applicants should contact: Parker A. Small, M.D., Department of Microbiology, Box J-266, JHMHC, Gainesville, FL 32610. An Equal Employment Opportunity/Affirmative Action Employer.

INTERNIST — NORTHERN NEW HAMPSHIRE. State-of-the-art, small hospital in White Mountains of New Hampshire requires internist for multi-specialty group. Competitive salary plus incentives and benefits. Pleasant, small town with good schools. Close to famous Balsam's resort; short drive to Sherbrooke, Canada. Send CV to: New England Health Search, 63 Forest Avenue, Orono, Maine 04473, or call 207-866-5680.

OB-GYN NEW HAMPSHIRE. Solo practice with coverage in well-equipped, busy, small hospital in Sunapee Lake region. Small, college community is 30 minutes from cultural and educational center; two hours from Boston. Send CV to: New England Health Search, 63 Forest Avneue, Orono, Maine 04473 or call 207-866-5680.

FAMILY PRACTICE — Great Opportunity to join a busy solo practioner in Lake Worth (West Palm Beach). Board Certification/Eligibility required. Contact Art Altbuch, M.D., 3918 Via Poinciana, Suite 5, Lake Worth, FL 33467, 305-433-1700.

GAINESVILLE, FLORIDA — Practice opportunity available immediately in ambulatory care centers. Excellent remuneration in a beautiful university city. Reply with CV to Florida Medical Association, Inc., P. O. Box 2411, C-1437, Jacksonville, FL 32203.

ORTHOPEDIST, BOARD CERTIFIED with Florida license, needed. Ready to retire to non-surgical practice with no investment and immediate income? Our PI/WC group needs you. Florida Regional Diagnostics, Orlando, FL 305-239-0202.

ORTHOPAEDIC SURGEON, COLORADO: BC/BE orthopaedist to join solo practioner in quality, diversified, established practice. Community of 40,000, 50 minutes north of Denver. Excellent environment, access, medical community and equipment. Share call with third. Business arrangements negotiable. CV/contact: Earle T. Howard, M.D., 914 W. 6th., Loveland, CO 80537. 303-669-7100.

FAMILY PRACTIONER /PRIMARY CARE PHYSICIAN/GENERAL INTERNIST. Well established 30 member multispecialty group needs 2 full-time board certified or eligible physicians. Fully equipped facility- laboratory, x-ray, CT scan, physical therapy, pharmacy. Administrative services provided. Fringe benefits. Excellent practice opportunity in one of the fastest growing communities in Florida, located on beautiful southwest coast. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1423, Jacksonville, FL 32203.

B/C or B/E INTERNIST wanted for busy, established in practice in beautiful resort community on Florida's west central coast. Opening immediately available. Financial renumeration negotiable. Unique opportunity for the right individual. Respond to: Box C-1412, P.O. Box 2411, Jacksonville, FL 32203.

BC/BE FAMILY PRACTICE or Internists needed in Lee County, FL. Career opportunity; office & hospital practice in new office. Attractive financial package with option to buy in full or part. Send resume to: MED-CENTER PLAZA GROUP, INC., Attn: Martin E. Dolence, Jr., CPA, 6314 Corporate Ct., #C, Ft. Myers, FL 33907 or call for an appt. (813) 489-2227.

ORTHOPEDICS, NEUROLOGISTS AND NEUROSURGEONS needed immediately and for 1988 for groups and multispecialty clinics. Opportunities throughout America. The Lewis Group, 1227 N. Valley Mills, Suite 200, Waco, TX 76710, 817-776-4121.

INCREDIBLE OPPORTUNITY, SARASOTA, FLORIDA — Unique medical complex, fastest growing, wealthest county. Seeking rheumatologist, otolaryngologist, etc. BE/BC. Complete financial assistance to help establish superior practice. Send CVs: Medical Center of Sarasota, 3982 Bee Ridge Rd., Exectuvie Suite, Sarasota, FL 34232 ATTN: Donald R. Briggs. 813-923-3637.

SUNBELT OPPORTUNITIES Available now for BC/BE physicians also accepting 88 residents. Complete confidentiality, please respond by sending CV or telephone: Frank B. Lane, M.D., Medical Director, Medical Consultants of America, 5121 Ehrlich Road, Suite 107A, Tampa, FL 33624, 813-968-3878.

JOIN 3 ABOG CERTIFIED MDs in quality practice of OB/GYNs in lovely Conn. New office facility with sonography, mammography, etc. L.I. Sound, Boston, Providence, New Haven, NY. Fishing, skiing, etc, all within easy commute. Good schools, low crime rate, no state income tax, reasonable malpractice rates: trees, grass, 4 seasons, etc. Equal opportunity. Please write with CV: Norwich OB/GYNs Group, Inc., 125 Sachem Street, Norwich, CT 06360, ATTN: Len Green, M.D.

GENERAL MEDICINE—Primarily internal medicine, family practice and geriatrics. Part-time associate wanted. can lead to full-time position if desired. No night call or weekends. Located in Largo, FL., 2 miles from Gulf beaches. Salary negotiable. Perfect position for semi-retired physician or physician starting practice. Contact: R. Chris Brown, M.D., 1890 W. Bay Drive., Largo, FL 34640. (813) 585-5190.

FAMILY PRACTICE: Great opportunity. Join solid group of four FPs in Central Florida. Low malpractice risk area. Abundant patients. Attractive town. Excellent school system. Marvelous place for family. Write: 306 S. Line, Inverness, FL 32652.

ACTIVE, WELL-ESTABLISHED, General Practice with bldg for sale. Gross $180,000 to $200,000 a year. Can be improved. Ideal for minority physician. FL Gold Coast. Write to: Box C-1413, P.O. Box 2411, Jacksonville, FL 32203.

HOLBROOK, ARIZONA a community of 7000 1½ hours from Flagstaff, has an excellent opportunity for a BE family practitioner doing limited obstetrics. Practice assistance package includes first year salary guarantee, free rent, and malpractice insurance. Contact PROSEARCH, 305 NE 102nd Avenue, Portland, OR 97220. 503-256-2070.

CARDIOLOGIST WANTED: BE/BC for excellent South Miami Cardiology practice. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1421, Jacksonville, FL 32203.

DIAGNOSTIC RADIOLOGIST, immediate opening, Tampa. Board certification, Florida license required. All modalities including magnetic resonance imaging. Attractive benefits, call 813-875-2818.

PRIVATE PRACTICE OPPORTUNITIES in General Internal Medicine and Cardiology in Central Arkansas community with 350 bed hospital. Establish a busy, lucrative private practice in a short time. Send CV to PO Box 1350, Pine Bluff, AR 71613 for more information.

FT. LAUDERDALE: Florida licensed physician wanted part-time to perform clinical exams in busy screening center. Flexible hours. Call Michele 305-742-3500.

ENT - Develop solo practice in semirural, family-oriented, southern Virginia town. Supported by 260 bed hospital, 20+ primary care physicians with three county drawing area. Outdoor amenities such as hunting and fishing; 2 hours from 6 mayjor medical schools. Strong compensation/benefits package including office setup, overhead contribution and malpractice. Contact Bobby, Tyler & Company, 9040 Roswell Road, Atlanta, GA 30350. Call 404-641-6411.

FAMILY PRACTICE — Independent contracted private practice opportunities in metropolitan Alabama with 275+ bed community hospital support. Recreational and cultural amenities. Compensation package: 70K$/insurances to include malpractice/3 weeks vacation/CME/annual contract negotiations with option to buy. Contact Bob, Tyler & Co., 9040 Roswell Road, Atlanta, GA 30350. Call 404-641-6411.

URGENT NEED: FL license doctors to fill needs of rapidly growing west coast community. Family Practice and internist. ALl hospitals are open staff. Send CV to P.O. Box 2411, Box C-1408, Jacksonville, FL 32203.

THE VETERANS ADMINISTRATION, Medical Center, Lake City, FL is recruiting for a board certified Psychiatrist. Will assist in estblishment of new Service in a progressive environment of inpatient and outpatient activity. Competitive salary plus incentive pay commensurate with qualifications. Liberal benefits plus malpractice insurance and retirement program. The North FL area offers an excellent climate year round, extensive outdoor recreational activities, lower than average cost of living, fine schools and nearby university, local community college, uncongested commuting to Medical Center. Contact John H. Beggs, M.D., Chief of Staff, VA Medical Center, Lake City, FL 32055, (904) 755-3016, Ext. 2011. An Equal Opportunity Employer.

OBERLIN, OH 20 person multispecialty group seeks additional BC/BE family physicians, internist, cardiologist, OB/Gyn and otolaryngologist. North central Ohio college town serving drawing area of 290,000. Salaried position first year; full shareholder status available in second year. Send CV to Dr. VanDyke, 224 W. Lorain, Oberlin, OH 44074.

WANTED: Certified Specialists in the field of Proctology, Radiology and General Surgery, Nuclear Radiologist to review medical records and to be available for court testimony. Send your CV to 118 Olympus Way, Jupiter, FL 33477. Or Call (305) 575-0505 or (800) 223-5981.

FAMILY PRACTICE: Opportunity to join three board certified F.P.s in a rapidly growing practice at the Beach. Excellent community to live and grow. Next to a large metro area. Practice is strong in wellness, preventive and psychosocial medicine. Salary negotiable with opportunity to buy in. Contact: North Beach Family Practice, Attn: Dr. R. D. Gottula, 100 Royal Palm Dr., Atlantic Beach, FL 32233. Or call (904) 241-5107.

FAMILY PRACTICE, RURAL COLORADO — BC/BE Family Practitioner to join three FPs in growing multi-specialty group. Excellent opportunity for person interested in rural living, mountain recreation, health care delivery for medically underserved populations. Send CV to Michael Bloom, 204 Carson Ave., Alamosa, CO 81101. 303-589-5161.

INTERNIST OR NONINVASIVE CARDIOLOGIST: Southwest North Carolina, Family-oriented, semirural tourist town 1-2 hours from Asheville and Atlanta. Supported by less than 100 bed hospital, 3-county drawing area of 70K. Outdoor amenities: hunting/fishing/camping/skiing/etc. Compensation: 1-year guarantee/office space/set-up support. Contact Bob, Tyler & Co., 9040 Roswell Rd., Atlanta, GA 30350. Call 404-641-6411.

EXCELLENT OPPORTUNITY FOR TWO BC/BE INTERNISTS AND TWO BC/BE OB/GYNS in rual setting.

Prepared to offer generous guarantee with clinic space adjacent to 80-bed acute care hospital located 80 miles north of Mobile, AL in East Central Mississippi. For information, contact Administrator, Wayne General Hospial, P. O. Box 590, Waynesboro, MS 39367. 601-735-5151.

SOUTHERN CALIFORNIA multi-specialty practice seeks Family or General Practitioner. Guaranteed salary plus incentives. Malpractice and health insurance provided. Spanish-speaking a plus. CV to Atlantic Avenue Medical Clinic, 7503 Atlantic Avenue, Cudahy, CA 90201.

PRACTICES AVAILABLE

OIAL large general practice and clinic for sale by GP preparing for retirement. Practice is part of a progressive and rapidly expanding community located in central Minnesota near excellent winter and summer recreation. Current clinic grosses more than $500,000 annually, is expandable and equipped with surgery, X-ray, lab and set up for pharmacy. Fee for service and growing! Malpractice insurance not a serious problem. Computerized, excellent staff. Great potential for aggressive GPs, FPs, internists or surgeons. Excellent hosptial one mile. Contact: Janet K. (612) 251-9191.

INTERNAL MEDICINE PRACTICE FOR SALE: 80 miles south Disney World, in central Florida. Retiring 28 years. Holter Monitor, Fiberoptics, complete lab, etc. Will introduce. Prefer Cardiologist or gastroenterologist. P.O. Box 2411, C-1418, Jacksonville, FL 32203.

FAMILY PRACTICE FOR SALE: High volume family practice, west coast of Florida, South of Tampa/St. Pete. Suitable for two physicians. Eight exam rooms all fully equipped, lab, x-ray, computerized business office. Expanding area, two local hospitals. For further information, contact Box C-1361, P.O. Box 2411, Jacksonville, FL 32203.

MIAMI BEACH AREA. Long established solo practice. Excellent terms. (305) 865-8747.

FLORIDA WEST COAST PRACTICE for sale. IM/FP. Wonderful life style. From office practice only, 30 hr/week summer, 40 hr winter. Grossed $125,000 with low overhead. Expansion possible if desired. Cost $50,000. Terms. Will introduce. Send short CV to Florida Medical Association, Inc. P. O. Box 2411, C-1425, Jacksonville, FL 32203.

BUYING A PRACTICE? We have opportunities in all specialties. Quality and personal attention are our trademark. Call for information now. Frank B. Lane, M.D., Medical Director, Medical Consultants of America, 813-968-3878. Also private practice opportunities available.

SOLO PRACTICE OPPORTUNITY — McKenney, Virginia. Office building available. Attractive financial terms negotiable, excellent hospital and community support. Near large regional medical center. BC/BE, Family Practice, Internal Medicine preferred. Contact Amy G. O'Bryan, Director, Physician Referral Service, Virginia Health Council, 3312 W. Cary Street, Richmond, Virginia 23221, 804-358-9944.

GOLD COAST: Lucrative Primary Care clinic is currently available. Grossing $3.6 million, netting $1 million. Price and terms negotiable. Direct inquires to Florida Medical Association, Inc., P. O. Box 2411, C-1422, Jacksonville, FL 32203.

OFFICE SPACE AND USE of playroom available in already established office at 4113 Bridgeport Way West in Tacoma, Washington. Desirable area for establishing a practice in the area of child, family and general psychiatry for a Psychiatrist who is interested in developing his/her own practice in conjunction with psychiatric evaluations and medication assessment of children, adolescents, and adults (mostly women). Please contact Vivian L. Ehly, R.N., B.S., M.S., for further information at (206) 564-0152.

GENERAL PRACTITIONER contemplating retirement. Rental situation: no real estate. Records, equipment, receptionist available. Terms reasonable. Sarasota. Write: P.O. Box 2411, Box C-1417, Jacksonville, FL 32203.

INTERNAL MEDICINE PRACTICE FOR SALE: in N.E. FL., well-established, excellent gross, will introduce. Write: Box C-1401, P.O. Box 2411, Jacksonville, FL 32203.

COASTAL PALM BEACH COUNTY established ophthalmology (anterior segment surgical) practice for sale. Office Surgical Suite, high gross, cost recoverable one year. Reply with CV to Box C-1397, P.O. Box 2411, Jacksonville, FL 32203.

RETIRING BOARD CERTIFIED OB/GYN selling or leasing completely equipped office. Capacity for 2 or more OB/GYNs. Prime location in Coral Gables-South Miami area, adjacent to hospitals. Will introduce. M. Hernandez, M.D., 420 South Dixie Highway, Coral Gables, FL. Phone: (305) 667-3677.

FOR SALE FAMILY PRACTICE retiring immediate occupancy. Professional building, long standing active practice. 5000 active patients - 1000 intermittent. In excellent community of main thoroughfare in Nassau County - 200 ft. across Queen's border. Ideal for new ambitious M.D. or relocation. 1200 sq. ft., 6 modern rooms, fully equipped with x-ray. Low overhead, 10 minutes from 3 hospitals. Huge inventory. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1433, Jacksonville, FL 32203.

SITUATIONS WANTED

INTERNIST WITH SUB-SPECIALTY training and FL license wishes to relocate along east coast. Write to Box C-1398, P.O. Box 2411, Jacksonville, FL 32203.

INVASIVE AND NONINVASIVE Cardiologists (2) for unique opportunity in Palm Beach County. Situation available November 1987. Call 305-394-7045.

INTERNIST: Board Certified Internist in Sherman, TX, seeks same for association for general internal medicine practice. Currently 8 year established practice with 2 offices. Area is 75 miles north of Dallas with nearby large lake. Salary or partnership negotiable. Call 214-868-2124 or write: 812 Pecan Grove, Sherman, TX 75090.

RADIOLOGIST, Board Certified. Broad based training and experience including invasive, CT & MR. Seeks position with group, hospital, multispecialty or solo. Administrative experience. Write Florida Medical Association, Inc. P. O. Box 2411, C-1420, Jacksonville, FL 32203.

GENERAL SURGEON, 54 years old, Board Ceretified Florida licensed. Seeking relocation. Consider Solo, Group, clinic, HMO, assisting, some general practice, etc. Write Florida Medical Association, Inc., P. O. Box 2411, C-1426, Jacksonville, FL 32203.

VASCULAR/GENERAL SURGEON: Board Certified General Surgeon with two-year Vascular Surgery Fellowship. Seeking private practice affiliation with busy group. Florida license; native of South Florida. Available July 1988. Write: P.O. Box 2411, Box C-1411, Jacksonville, FL 32203.

WANTED: INTERNAL MEDICINE or family practice in Palm Beach County or North Broward Counnty. Other exceptional practices also considered elsewhere in Florida. Call: (305) 622-7661, (305) 831-9305, Work: (313) 745-5111, Beeper: 8272.

FAMILY PRACTICE — Board Certified FL license, looking for private practice opportunity (solo, partnership, group) in Orlando. Willing to buy. Write: Box C-1415, P.O. Box 2411, Jacksonville, FL 32203.

REAL ESTATE

NORTH CAROLINA MOUNTAINS REAL ESTATE: Sacrifice, must sell 3-year-old dream house in Blowing Rock with magnificent 280° view overlooking Appalachian mountain ski slopes. Customer decorator appointed features throughout this 3bdr, 2½ bath all cedar home. Includes Jacuzzi, billiard table, brick hearth with Jenn-Aire, gold plated plumbing fixtures, teakwood foyer, heartshaped fireplace, wet bar, red oak kitchen cabinets, red oak plank flooring in game room, triple pane glass throughout, vaulted solid pine ceilings, 1,530 feet of wrap-around decks and double garage. $250,000. Furn. Color photos available to the serious buyer upon request. Days: (704) 262-0009, Evenings call (704) 295-3939.

ORANGE PARK: medical building attached to Humana Hospital. 1,300 sq. ft. (and up) medical suites for lease. Excellent parking. Minutes to Jacksonville, quality building. P.O. Box 2639, Orange Park, FL 32067. (904) 276-5362.

MEDICAL OFFICE FOR SUB-LEASE in N. Palm Beach (on US Hwy. 1). Fully equipped with laboratory, X-ray, ECG, treadmill, low rent. (305) 627-3130.

PINE TREE FARM SALE: 1,090 rolling acres. 3/4 miles paved highway frontage and 2 miles county maintained dirt road frontage. Madison, FL. Call (904) 973-6030.

OFFICE SPACE TO SHARE with one or two physicians. 3,500 sq. ft. Full laboratory. X-ray machine. Excellent North Palm Beach location. Terms negotiable. Call John A. Swenson, M.D., (305) 844-2553.

WILL SELL OR LEASE ALL, OR LEASE PART (1200 sq.ft. to 1500 sq.ft.) Daytona Beach Medical Office Condominium within walking distance of Humana and Halifax Hospital Medical Center. 3200 sq.ft. total. Excellent condition. Call 904-255-0278.

LOW MONTHLY RENTAL: Fully improved 1st floor medical suite in established downtown Boca Raton, FL. Medical/Dental Bldg. - 1302 Sq.ft. Call 305-391-1900.

PLANTATION, FL PROFESSIONAL BUILDING FOR SALE. 18,600 sq.ft. 90% Rented. Space available for medical. Prime location. Terms. Kenneth G. Lewis, Interamerica Marketing, Inc., Broker, 305-983-1500

OFFICE FOR LEASE 1630 sq.ft. building in University Professional Center near Memorial Hospital in Jacksonville. Excellent location. Call John Poitevent, CI Properties, Inc. (Realtor) (Mon.-Fri., 9-6) 904-731-0018.

MEDICAL OFFICE SPACE, BRANDON, TAMPA SUBURB, LEASE OR SALE. New colonial building. One block from 300 bed hospital. Build interior - your specifications. Sq. ft. flexible. Equity participation plan available. Details - Charlie Banks 813-229-2451.

SERVICES

UNSECURED LOANS: No collateral, confidential, $5,000 to $60,000, competitive rates, no points, no repayment penalties. Information, application, Call (800) 331-4952, Department 32 or write: P.O. Box 9739-J, Pompano, FL 33075.

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

DISTRIBUTORS, BUYERS, of High Technology Diagnostic Medical Intruments. Holters, Scanners, Ultrasound, EKGs, ICU monitors, Defibrillators, Laboratory Equipment. New or reconditioned. Contact: New Life Systems, Inc., P.O. Box 8767, Coral Springs, FL 33075. Or call (305) 972-4600 or (800) 330-TELL.

MEDSTAFF is a multispecialty locum tenens and permanent placement service. The most respected physician staffing group in the Southeast can provide you with coverage or work as our staff physician. Call: in the U.S. (800) 833-3465; NC (800) 672-5770; or write Medstaff, P. O. Box 15538, Durham, NC 27704.

PRACTICE VALUATION AND SALES. Retiring or relocating? Let the nation's largest medical practice appraiser and sales consultatnt help you. Call or write for our free appraisal kit. RH Medical Group, Inc., 12651 Briar Forest Suite 180, Houston, TX 77077. (713) 496-777

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EQUIPMENT

X-RAY MACHINE: Raytheon Medical Systems FT-35 with Fischer processor. Two years old in excellent condition. Call (813) 729-6818.

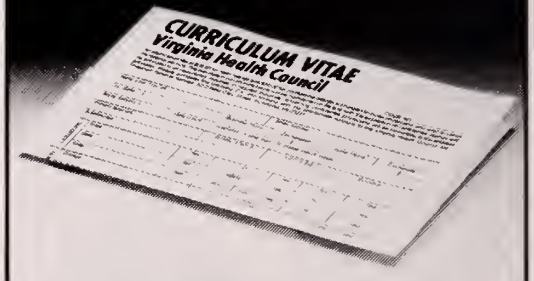
HOLTER MONITOR: Quality scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretation, scan price $35.00. Recorders loaned, leased or purchase new dual-channel holter recorder, $750.00 with two year warranty. For more information call collect, Advance Medical & Research Center, Inc., (313) 373-1199.

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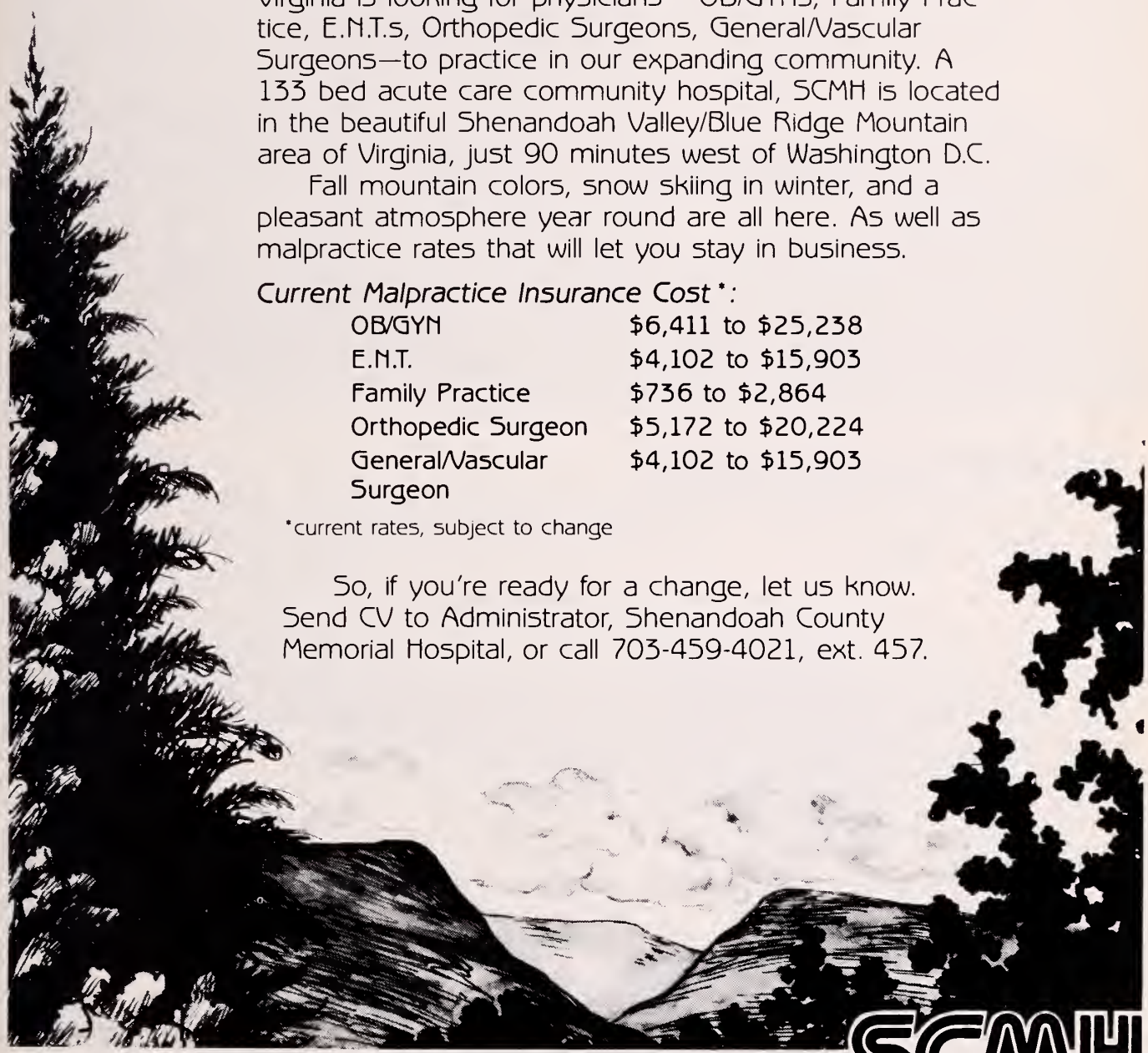
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ADVERSE REACTIONS: Muscle cramps, dizziness, hypotension, headache and nausea, and encephalopathy (in patients with preexisting liver disease).
Less frequent clinical adverse reactions are weakness, impaired hearing, rash, pruritus, hives, electrocardiogram changes, abdominal pain, arthritic pain, musculoskeletal pain and vomiting.
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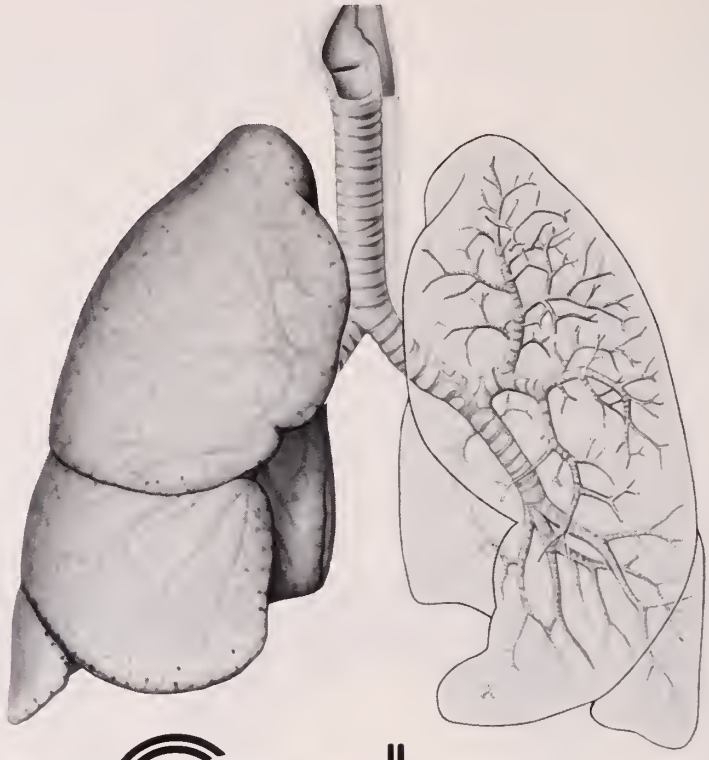
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- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

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James G. White, M.D., was installed as the 111th President of the Florida Medical Association in Hollywood on September 19, 1987. Dr. White is a pediatrician in Ormond Beach.

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PRESIDENT'S PAGE

Looking ahead with optimism



A new year began for the Florida Medical Association on September 19, 1987, and I am honored to have been elected to lead an outstanding group of physicians during this time. I have never witnessed such an outpouring of support and offers of assistance in what promises to be an exciting year for the Florida medical family. I say "family" because that is what we are — physicians, auxilians and staff, all working together to preserve our profession.

Our image has suffered over the past decade and we must accept part of the blame. We became less concerned about the patient as an individual and more concerned with our own welfare. This has troubled me a great deal and has prompted me to select as our theme for this year: "Back to Basics."

We must become more interested in our patients and listen to what they are telling us. They may not like organized medicine as such, but they love you as their doctor.

We also need to become more involved in our communities. We should have at least one physician on the sidelines at all junior and senior high school football games. In many areas, the chiropractors have been more than willing to step in to fill our void. We should actively participate in the Chambers of Commerce, School Health Committees, and in local government and charitable organizations.

I am pleased to say that by the time you read this our constitutional amendment will have been submitted to the Florida Supreme Court. We were successful in getting the necessary 34,000 signatures, largely through the Herculean effort of our auxiliary, under the able leadership of Mrs. Susan Marks and assisted by our staff. When the Supreme Court rules that the amendment does, in fact, address only one subject and, therefore, is constitutional, we must immediately turn up the heat to complete the task of getting the remaining 300,000-plus signed petitions. With 15,000 members, we can easily exceed that goal if we each sign up only 30 people.

I would also like to thank the House of Delegates for its forward thinking in passing the $500 assessment so that we can adequately finance a full-fledged campaign. We also expect to receive substantial support from the power companies, telephone companies, railroads and associated industries, as well as members of the Coalition for Liability Reform.

I am very optimistic about the coming year. We have a window of opportunity to solve the PLI problem that has literally consumed us far too long. With your continuous help and support, we will win.

Thanks again for permitting me to serve our great Association.





James G. White, M.D.
installed as
111th FMA President
by James B. Perry, M.D.

James G. White, M.D.: The new president of the FMA

If Dr. James G. White, as a young man, could have peered into his future 36 years ago, he would not have believed what he saw.

In 1951, fresh from high school and with the Korean War just beginning to heat up, young Jim left his hometown of Charlotte, North Carolina, with romantic visions of entering the U.S. Air Force to become a jet pilot. But his ambitions were crushed early when he found out that he had failed the eye examination. Goodbye Korea. And so much for being a top gun.

Although he stayed in the Air Force, his odyssey ended after four years working as a B-29 radio operator. He returned to North Carolina, enrolled at the University of North Carolina in Chapel Hill where he garnered a chemistry degree in 1959 and his M.D. degree four years later. When he went to the University of Florida in Gainesville for his training in pediatrics, little did he realize that this was going to be the springboard to his rise from the ranks to the top of the FMA.

What happened is a remarkable story of being in the right place at the right time, of meeting the right people, and of making choices at the right time.

On September 19 this year, amidst impressive ceremonies in a jampacked convention hall at the Diplomat Hotel, Jim saw the culmination of his political career when he was sworn in as the 113th President of the FMA, the first ever from Volusia County to assume the high position. It was a proud moment for Jim, for his family, and for the large contingent of friends and colleagues from Volusia who trooped in to witness the occasion.

As the new top gun of the FMA, Jim will be facing challenges that eluded him 36 years ago. But he is ready: he is well-schooled in the hard knocks of politics and is as prepared as any leader can possibly be. With 21 years of involvement with the FMA, Jim has held countless positions of leadership and responsibility both on the county and state levels.

Jim's passion for medical politics actually began when he was an intern and a resident in pediatrics in Gainesville between 1963 and 1966. There, one of his illustrious mentors, Dr. Gerold Schiebler, taught him not only about care and compassion for patients, but also about the importance of the political process. Gerry passed on to him a valuable little secret: Never stick your neck out until you know the votes are in. Jim remembered those lessons well.

From Gainesville, Jim went to the Daytona Beach area to join another pediatrician in practice. While in the office of his lawyer to have a partnership agreement drafted, he met his future wife, Beebe Shepherd, whom he married after a whirlwind three-month courtship. It was a perfect match-up. Beebe shared Jim's political commitment; along with several other couples in the area, they formed a supper club which eventually became the hub of their political interests and their subsequent campaigns. Two very close friends and club members — Hyatt Brown and Sam Bell — got elected and became very influential members of the House of Representatives. Beebe, for her part, focused her efforts on championing the cause of education and eventually got elected to the Volusia County School Board where she has been the chairman for the past several years.

It was in 1972, when Jim was the president of the Ormond Beach Rotary Club, that he began his earnest involvement with organized medicine. He headed several committees before becoming the chairman of the Legislative Committee of the Volusia County Medical Society in 1976, and two years later became the president of the society. Physicians across the state realized what Jim had been preaching all along: there

were drastic changes taking place in medicine and a lot of those changes were being made right in Tallahassee. Tallahassee became a battleground and Jim was out in front of the fray campaigning hard for the interests of the medical profession.

The FMA soon took notice of Jim's legislative skills and his extensive contacts in Tallahassee. In 1975, at the first outbreak of the malpractice problem, he got appointed to the FLAMPAC Board, becoming the Vice Chairman in 1983, and currently heads the Candidate Selection Committee. In 1978 the FMA also tapped Jim to the Council on Legislation and later made him the Chairman of the State Committee on Legislation (1981-1983). Between 1979 and 1981, then FMA President Dr. Richard Hodes appointed him to the Board of Governors.

A landmark year in Jim's political life was 1983. Having demonstrated his skills before his peers, particularly in the legislative arena, he was now ready to test the waters for an elective top position in the FMA. He launched his candidacy for Vice President that year, campaigned hard as he always did, and came home a winner against a candidate fielded by the mighty Dade medical society. After three years at the post, Jim ran unopposed as the President-Elect in 1986.

Despite the traditional adversitites, Dr. White remains optimistic that the FMA will finally be able to lick the long-standing PLI problem.

Jim steps into his new job amidst the maelstrom of a long-raging controversy: the unresolved professional liability problem. Against a background of a looming crisis, he made clear that finding a solution to the problem will remain the top priority this year of the FMA. As a measure of that resolve, the House of Delegates passed during the annual session a resolution asking for a mandatory assessment of $500 from each FMA member to support legislative and constitutional tort reform campaigns. The FMA, according to Jim, will step up efforts for a constitutional amendment seeking caps on noneconomic damages to $100,000, and will press the state legislature for enactment of the Medical Incident Compensation Act (MICA) to replace the current tort system. Jim is optimistic that the FMA will finally be able to put behind a problem that has haunted it for the last 12 years.

Although the PLI issue will consume most of Jim's time, he is not going to neglect other areas of critical concern to the medical profession. He has selected "Back to Basics" as the theme of his presidential year. The cornerstone of this theme involves the improvement of the physician's public image, the restoration of caring for patients as people, and improved communication between the physician and the patient.

As part of that theme, Jim will also be reaching to the grassroots of the FMA membership for their ideas and to let them know that their problems and concerns are as much the problems and concerns of the FMA leaders and the Board of Governors. Along this line, a committee will be working to broaden the FMA membership and to encourage physicians to participate more in FMA activities.

The schedule that Jim faces looks tough by any measure and will entail his being away from his busy pediatric practice in Ormond Beach for long stretches of time. But he took care of that a year before he made a commitment to become the president of the FMA. In 1986 he wrote to all the parents of his patients telling them of his plans and asking them if they would not mind having their children seen by two other pediatricians who would cover for him in his absence. More than 99% wholeheartedly endorsed his plans and told him to go ahead. That was very satisfying for Jim; the parents knew this was a rare opportunity for a man they know quite well to serve the interests of all physicians and their patients in Florida.

Jim will also have the support of those who are not his patients, particularly his family. Jim is a devout family man, and nothing felt more exhilarating than when he introduced each family member to the audience during his inauguration. His wife, Beebe, will be spending more time traveling with him around the state in caucuses and meetings. His oldest son, Jamie, is married and happily settled in Gainesville, while Mark, the younger son, is retracing his father's footsteps as a sophomore pre-med student at UNC. Merri Beth, the youngest at 16, is a junior student in high school and likely will be seeing less of Daddy for the next one year.

If Jim finds a break from his demanding schedule, he will likely tee off at the greens for a game or two with his favorite golfing buddies. His love of the game is second only to his love of medicine. Oh yes, lest anybody forget, Jim will be piloting his own small plane when he travels around the state for the FMA. Just like the jet pilot he used to dream about 36 years ago, but this time he will have much better vision.

R. G. Lacsamana, M.D.
Editor

The 113th Annual Meeting of the Florida Medical Association

The 113th Annual Meeting of the Florida Medical Association was held September 16-20 at the Diplomat Hotel in Hollywood. Last year's meeting brought about the change of dates from May to September and the opening of the House of Delegates on Thursday morning instead of Wednesday. These changes seem to be working well and were continued this year.



James B. Perry, M.D., FMA President addresses the House of Delegates.

Although the official opening of the House was Thursday, other FMA activities took place Wednesday. Hospital medical staff representatives met with the FMA Council on Hospital Medical Staffs, while FMA awards for excellence in medical journalism were presented at a luncheon. The Florida Medical Association Auxiliary House of Delegates began its deliberations, and hosted a tropical luau for all FMA and FMA-A members that night.

The first session of the 396 member House of Delegates, the policy making body of the Association, opened Thursday morning. Each county is represented by one delegate for each 40 members, while each of 39 specialty societies is entitled to one delegate. The first session of the House consisted of the presentation of awards, the president's remarks, and the referral of business to the appropriate reference committees.



Past JFMA Editor Clyde M. Collins, M.D. and Present Editor R. G. Lacsamana, M.D.

The annual Editor's luncheon was held Thursday noon with *The Journal's* editor R. G. Lacsamana, M.D., honoring the winners of *The Journal's* Tenth Annual Awards Contest for County Medical Society Bulletins. They were:

CATEGORY I — General Excellence: Newsletter Format - **First Place** - *Escambia County Medical Society Bulletin*; Magazine Format - **First Place** - *Miami Medicine*, Dade County Medical Association.

CATEGORY II — Most Improved Bulletin: First Place - *On Call*, Palm Beach County Medical Society; **Special Recognition** - *Central Florida Physician*, Orange County Medical Society.



FMA Speaker of the House Guy T. Selander, M.D. and Gaston J. Acosta-Rua, M.D.

CATEGORY III — Best Editorial: First Place - *Marion County Medical Society Bulletin*; **Special Recognition** - *Picomeso Mail Bag*, Pinellas County Medical Society; **Special Recognition** - *The Stethoscope*, Volusia County Medical Society.

CATEGORY IV — Best Regular Feature: First Place - *Central Florida Physician*, Orange County Medical Society; **Special Recognition** - Hillsborough County Medical Association Bulletin; **Special Recognition** - *The Stethoscope*, Volusia County Medical Society.

CATEGORY V — Special Recognition: First Place - *Miami Medicine*, Dade County Medical Association; **Special Citation** - *Hillsborough County Medical Association Bulletin*; **Special Citation** - *Brevard County Medical Society Bulletin*.



The 1987 Florida Medical Association Board of Governors poses for the first time after the final session of the House of Delegates. Seated (left to right): Treasurer Dick L. Van Eldik, M.D., Lake Worth; Secretary Henry M. Yonge, M.D., Pensacola; President James G. White, M.D., Ormond Beach; Vice President Kay K. Hanley, M.D., Clearwater; President-Elect Yank D. Coble Jr., M.D., Jacksonville; Speaker of the House, Guy T. Selander, M.D., Jacksonville; Immediate Past President, James B. Perry, M.D., Fort Lauderdale. Standing: Gerold L. Schiebler, M.D., Gainesville; Calvin W. Martin, M.D., Arcadia; Richard J. Bagby, M.D., Winter Park; Joseph C. Von Thron, M.D., Cocoa Beach; Vice Speaker Arthur L. Eberly, M.D., Lighthouse Point; Keith E. McManus, M.D., Orlando; A. Frederick Schild, M.D., Miami; Alvin E. Smith, M.D., Ormond Beach; Margaret C. S. Skinner, M.D., Miami; Executive Vice President Donald C. Jones, Jacksonville.

Following the luncheon I attended a special meeting of the Florida delegation to the American Medical Association. Our delegation meeting was held at this time to allow us to spend some time discussing issues and items that we do not have time to discuss when we are at the sessions, even though we begin each morning with a Florida caucus at 6:30 or 7:00 a.m. Florida is well represented in the AMA with 12 delegates and 12 alternates, each of whom takes an active role in representing you at the two meetings of the AMA House of Delegates each year.

The delegates were up bright and early Friday morning to attend the reference committee meetings. All business to be debated before the full House of Delegates is referred to one of five reference committees for discussion. Delegates serve as members of the committees and hear testimony on each item referred to them for consideration. After taking public testimony, the committee adjourns to closed session to write a report of their recommendations. This report is then presented to the House as they consider each item.

Specialty society scientific sessions were held Friday afternoon and Saturday morning. Most of these sessions provide continuing medical education credit and are a much needed break from the burden of spending four days dealing with the many socioeconomic problems facing medicine. Technical and scientific exhibits were available for viewing during this time.

The second session of the House began Saturday afternoon. Reference committee reports were heard and action taken on resolutions. Candidates for FMA office were nominated for the election to be held Sunday morning. Following this session of the House, James G. White, M.D., was inaugurated as the 111th President of the FMA. A reception in honor of Dr. White, Mrs. Betty Orr, President of the FMA Auxiliary, James B. Perry, M.D., FMA Immediate Past President, and Mrs. Susan Marks, FMA-A Immediate Past President, followed the inauguration ceremony.

While the House was completing its work Sunday morning, votes for officers were counted. Elected to FMA office for the coming year were Yank D. Coble Jr., M.D., President-Elect; Kay K. Hanley, M.D., Vice President; Henry M. Yonge, M.D., Secretary; Dick L. Van Eldik, M.D., Treasurer; Guy T. Selander, M.D., Speaker of the House; Arthur L. Eberly Jr., M.D., Vice Speaker.





The tropical luau was enjoyed by all (A) Donald C. Jones and Joseph T. Ostroski, M.D. (B) Dr. and Mrs. V.A. Marks.

All FMA members will receive a complete copy of the actions taken by the House, and the entire proceedings will be published in the December issue of *The Journal*. Here is a partial list of the actions taken by the House.

- Voted to seek legislation to significantly revise the professional review organization statutes as now written and implemented through HCFA guidelines to reflect the community standards for quality of care.
- Seek a constitutional amendment to limit awards in all liability cases to $100,000 for noneconomic damages.
- Assess FMA members $500 to support legislative and constitutional tort reform, with the Board of Governors deciding at what date this becomes necessary and mandatory, and that the assessment not be levied until the Supreme Court rules that our constitutional amendment has been properly worded.
- Referred Resolution 87-17, a lengthy policy statement on AIDS testing, to the Board of Governors.
- Called for a maximum of 0.05 percent blood alcohol level standard for operators of motor vehicles as prima facie evidence of a violation of driving under the influence (DUI) laws.
- Support legislation to maintain the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA's ethical guidelines.
- Seek legislation that requires an expert witness giving testimony in court or by deposition to be licensed and actively practicing medicine in Florida, have practiced in the specialty about which he will be testifying for at least the past four years, and require that the plaintiff's attorney obtain a written opinion from an expert witness so qualified that a cause of action exists, prior to filing a claim.
- Plan for a membership rally in Tallahassee at the time of the special legislative session.

Lee A. Fischer, M.D.
Associate Editor
West Palm Beach

PHYSICIANS, SCHEDULE SOME TIME FOR YOUR COUNTRY.

Many physicians would like to devote some time to their country in a local Army Reserve unit. We know that making a weekend commitment can be difficult for most physicians. So it is practical for the Army Reserve units to be flexible about time. It's worth discussing.

Incidentally, in addition to satisfying your own desire to serve your country, there are exceptional opportunities to do something totally different from a day-to-day routine. Opportunities to study new areas of medicine, meet new people in your specialty, and be a part of one of the world's most advanced medical teams.

Discuss the opportunities with our Army Medical Personnel Counselor.

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You'll also have an opportunity to participate in a number of programs in which you'll be able to exchange views and information with other surgeons from all over the country.

The Army Reserve understands the time demands on a busy physician, so you can count on us to be totally flexible in making time for you to share your specialty with your country. We'll arrange your training program to work with your practice.

To find out about the benefits of serving with a nearby Army Reserve unit, we recommend you call our Army Medical Personnel Counselor.

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One, time. We know how tough it is for a busy physician to make weekend time commitments. So we offer flexible training programs that allow a physician to share some time with his or her country. We arrange a schedule to suit your requirements.

Two, the opportunity to explore other phases of medicine, to add a different kind of knowledge—the challenge of military health care. It's a flexibility which could prove to be both stimulating and rewarding, with the opportunity to participate in a variety of programs that can put you in contact with medical leaders from all over the country.

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Court-mandated procedures permit withdrawal of sustenance with no criminal or civil liability

I am the Corbett who initiated the case, Corbett v. D'Alessandro, Apr 18, 1986, 487 So 2d 368, so you can understand my deep interest in the excellent article in your August 1987 issue by Doctors Ray Moseley and James A. Jernigan. This article, "Withdrawing Medical Treatments: The Difficult Case of Withdrawing Nutrition," deals with the Corbett Case and the effort to amend the "Life Prolonging Procedures Act of Florida" to permit the withdrawal of nutrition under certain circumstances. I sent heavy mailings to each member of the Legislature and made a trip to Tallahassee in behalf of this proposed amendment. I worked for this amendment, not because it was needed to legally withdraw nutrition, but because certain interests were at work throughout the state denigrating the Corbett Case as somehow insufficient or not to be relied upon in granting immunity to doctors. I shall show how the Corbett Case and John F. Kennedy Hospital v. Budworth, 452 So 2d 921 (Fla. 1984) are all the law Florida needs on this subject.

A quotation from the court decision in the Corbett Case will make clear that immunity from prosecution was granted:

> "Appellant (Corbett) and the health care professionals attending Mrs. Corbett were reluctant to discontinue sustenance by nasogastric tube without judicial intervention and approval for fear of civil and/or criminal liability. Appellant (Corbett), therefore, sought declaratory relief as to the propriety of the discontinuance of the nasogastric tube. The trial court denied appellant's request for relief We agree that the trial court erred in holding that there was no Federal or State Constitutional right to privacy on which appellant could sustain the withholding of nasograstric forced sustenance to Mrs. Corbett We reverse the holdings of the trial court."

With this sentence from the last paragraph of the decision, the Court of Appeals granted the declaratory relief denied by the trial court. This is relief from prosecution on criminal or civil charges if the procedures are followed. The court in the Corbett Case requires the procedures as set forth by the Florida Supreme Court in the Kennedy Hospital Case. The Supreme Court of Florida requires that the attending physician and two other physicians of relevant medical specialty concur on the diagnosis and prognosis. Of course the patient or patient's proxy must also approve. All approvals should be given in writing and made a part of the medical record. This procedure should be followed in cases of irreversible coma (permanent vegetative state).

Patients in irreversible coma are often not considered to be terminally ill because they may keep breathing for years until some other condition causes death. Since death is not considered imminent and since the Florida statute requires that the patient must be terminal and death must be imminent, the procedures required by the Florida Supreme Court in the Kennedy Hospital Case should be followed.

The Corbett Case did two things. It made possible the removal of sustenance from a patient in irreversible coma under procedures prescribed by the Florida Supreme Court. The Corbett Case also effectively repealed that part of Chapter 765.03(b) which states, "The term 'life prolonging procedure' does not include the provision of sustenance." Thus any physician is free to look upon the provision of nutrition as medical treatment, either comfort care or as a life prolonging procedure. According to the statute any life prolonging procedure may be removed, with approval of the patient or patient's proxy, if the patient is terminal and death is imminent.

It is important that the court procedure rather

than statutory procedures be followed if death is not imminent. In addition to the attending physician the court requires two doctors, qualified in specialties relevant to the patient's condition, to make sure that the coma is irreversible. These specialists should be neurologists or neurosurgeons. The neurologist who diagnosed my wife, Helen Corbett, would require six months in a coma before declaring the condition irreversible. Coma patients either get better or die in six months. If they are still breathing at the end of six months and still exhibit the vegetative symptoms, procedure may be followed to withdraw nutrition. A neurosurgeon also made the diagnosis for Helen Corbett after a craniotomy and 19 days in the hospital. She lived 35 months in irreversible coma and died before the Corbett Case became final.

I cannot conceive of a state attorney anywhere in Florida bringing criminal charges of murder or manslaughter against any health care professionals for removing forced feeding from any terminally ill patient where death is imminent or from a patient in the permanent vegetative state. Helen Corbett was not terminally ill according to the testimony of three physicians. She was in the vegetative state.

The Florida Supreme Court in the Kennedy Hospital Case ruled as follows:

> "To be relieved of potential civil and criminal liability, guardians, consenting family members, physicians, hospitals or their administrators need only act in good faith. For them to be held civilly or criminally liable, there must be a showing that their actions were not in good faith but were intended to harm the patient. Under the circumstances of this and similar cases, prior court approval is not required."

The Life Prolonging Procedures Act of Florida, Chapter 765.07, lists decision makers in order of priority if no individual in a prior case is reasonably available, willing and competent to act: judicially appointed guardian of the person of the patient if such guardian has been appointed. No appointment of a guardian is required. Next is the person designated in writing by the patient, then the patient's spouse, an adult child of the patient, the parents of the patient, the nearest living relative of the patient.

In the Kennedy Hospital Case the Supreme Court of Florida said: "The decision to terminate artificial life supports is a decision that normally should be made in the patient-doctor-family relationship." It is not necessary to obtain court orders unless some institutional policy stands in the way. Moving the patient may be easier.

I am currently working on a manual to aid patients in writing their advance directives and to help those confronted by legal and ethical aspects of these matters. Many people will require reassurance of the complete texts of the Florida statute and the pertinent court cases.

Doctors have rights as well as patients. The statute suggests that a physician who does not wish to abide by a patient's living will and remove life support when death is imminent should refer such a patient to another physician. In this age of highly specialized physicians, all professionals may not feel fully expert in comfort care, anesthesia, pain control, and heavy sedation. Grieving family members also sometimes present problems of a specialized nature. There are perfectly acceptable reasons for not wanting to participate in treatment withdrawal. Inadequate legal protection is not one of those reasons. There are large hospitals on both coasts of Florida following case law on these matters.

Thomas E. Corbett
Cape Coral

Dissent from St. Paul

The August editorial, "The Task Force Report on Tort Reform: A Bugle Call for Drastic Changes," offered several thought-provoking comments on the medical liability issue in Florida. Unfortunately, the editorial provided an inaccurate account of the activities of insurance companies and an unrealistic view of the medical liability insurance business.

The alleged "spectre of insurance companies doing business when business is good and leaving their clients bare and empty when business is not so good" misrepresents the decision of St. Paul Fire and Marine Insurance Company — the largest single medical liability insurer in Florida — to cease as a market for physicians' and surgeons' coverage in the state as of December 31. That difficult decision was made only after The St. Paul determined that it could not foresee the ability to obtain adequate rates for medical liability insurance in Florida in the future.

The number and cost of medical liability claims against St. Paul-insured doctors in Florida are among the highest in the country. Those high claim costs, however, could still be covered if medical liability rates were adequate. The St. Paul is writing liability coverage for Florida for one final six-month policy term because the Governor, the state Insurance Commissioner, and other state leaders asked The St. Paul to remain for one more term to give the state time to develop long-term solutions to the medical liability problem.

We are writing those policies at rates lower than what we filed. These rates — while sufficient to minimize further operating losses — are inadequate to provide even a marginal profit. Based on the indications of the state Insurance Department, we cannot be assured adquate rates in the future, and therefore do not foresee a long-term future for us in the physicians' and surgeons' liability business in Florida

(although we continue to write other medical and other types of liability insurance in the state).

The decision to cease writing doctors' coverage in Florida was far from arbitrary or capricious, but was made only after many meetings with the Insurance Department and Florida leaders, and after suggesting several options to state regulators. No business, however, can long continue to operate when it is prevented from charging a price that covers costs and offers the prospect of a reasonable profit. Your suggestion that certain insurers, who may be forced by fundamental economics to stop writing such coverage, be "fined and barred from doing business altogether" makes little sense. It ignores the source of rising medical liability insurance rates — rising liability claim costs. Insurance passes through the costs of those claims to users of the medical liability system. When the costs go up, so too must the rates for liability insurance.

David G. McDonell
Senior Public Relations Officer
The St. Paul Companies, Inc.

The Florida malpractice insurance crisis of 1987: Perspectives from a retired legislator

For many years the entire tort system of this country has moved toward routine compensation of injured parties, *regardless of fault by the injuring party;* this in spite of the total lack of a mechanism to spread the cost over the general public in Florida. Thus, physicians have been and still are the legal system's *"deep pocket,"* and you can be sure that the lawyers will continue to "fight to the death" to preserve this antiquated, totally unfair system, based on selfishness and greed.

The six major groups involved in this crisis are outlined below. The contributing factors of each group are listed. Perhaps the Legislature and the public will be better able to decide which group is largely to blame and then demand that corrective legislation be passed. The author believes that the attorneys are 75% at fault:

A. The Patients
B. The Insurance Companies
C. The Doctors
D. The Lawyers
E. The Hospitals, the State, and the Legislature
F. The Juries

A. Patients

1. Cannot differentiate between an *unexpected or a poor result;*
2. Are constantly bombarded by deceptive attorney advertising, mail and telephone calls from attorneys after accidents or hospital stays;
3. Fail to understand complicated consent forms because frequently a nurse — *not the family doctor* — does the explaining;
4. May not feel that their doctors explain their medical problems to them and their families — the patient-doctor relationship may be cool, distant and unfriendly;
5. May have the concept their doctor is rich and can afford to pay for liability suits.

B. Insurance Companies

1. Drop doctor coverage, but still write other types of insurance in Florida. The insurance commissioner should revoke their licenses in these instances;
2. Settle "nuisance" or "spurious" suits out of court (saves court costs and attorneys' fees) even if the doctor is not guilty of negligence. This is a *major cause of high premiums;*
3. Use unrealistic criteria to compute actuarial predicted losses to elevate premiums.

C. Doctors

1. Failure to establish a concerned and caring doctor-patient relationship in some cases;
2. Failure to *personally* explain and see consent form signed by the patient;
3. By going to court to collect a bill from a dissatisfied patient;
4. Failing to keep *complete* medical records, and *changing* a record when called for a deposition or a court appearance;
5. Failing to call consultants on a timely basis;
6. Using experimental drugs or treatments not approved by the FDA.

D. Lawyers

1. Use "moles" (spies) in hospitals and emergency rooms to inform them of serious medical and accident cases;
2. Persuading patients to sue when the lawyer knows the case has no merit;
3. Calling and writing patients discharged from hospitals, and trying to persuade them to sue their doctors. These methods are inherently dishonest and only serve to further escalate the problem;
4. By opposing any legislative reform that does not provide a "deep pocket;"
5. By persuading the Florida Supreme Court in 1980 to declare the *Medical Mediation Panel* unconstitutional;
6. By opposing a *special legislative session* this fall fearing tort reform.

E. Hospitals, State Board of Medicine, Legislature

1. Hospitals — By mandating that doctors must carry a $1,000,000 policy as a prerequisite for staff membership. This places a severe burden on primary care physicians that may not need that much coverage.

Some hospital boards, executive committees, and medical association committees are not reporting disciplinary actions taken against staff members to the Board of Medicine. Failure to report these actions to the Board of Medicine allows a doctor to resign from one hospital staff without prejudice and then go to another local hospital and apply for membership. Prompt reporting of disciplinary actions will reduce the number of substandard doctors allowed to practice in Florida.

2. Board of Medicine — The Board has no mechanism to hear cases of gross criminal negligence on a current basis. Therefore, there are no speedy hearings or license revocations in these cases. The Board, at present, holds hearings only for doctors who have been sued for negligence three times in five years for amounts of $10,000 or more. Legislative action is urgently needed.
3. Legislature — Attorneys occupy many seats in the state legislature and exert great influence over their colleagues. They count on the *Academy of Trial Lawyers, The Florida Bar, State Attorneys,* and the *State Judicial Association* to effectively lobby the Legislature. Result — NO DEEP POCKET — NO CHANGES, and, of course, NO TORT REFORM. The Legislature requires all doctors, as a prerequisite of licensure, to carry $250,000 malpractice insurance. The doctors feel that the decision whether or not to carry malpractice insurance should be theirs, and theirs alone.

F. The Juries

1. Colossal jury awards are not the fault of the juries. They arrive at verdicts on the basis of their *emotions* because they simply cannot understand and evaluate medical terms. Except for *criminal negligence,* malpractice cases should be heard by special hearing officers or panels.

The author hopes that this article will be of assistance to all parties concerned so that meaningful tort reform will be passed by the Florida Legislature this fall.

David J. Lehman, M.D.
Hollywood
Retired Member of Florida Legislature (1974-1984)
Retired Internist

Solving the liability crisis requires massive changes in the tort system

The observer of the medical liability crisis cannot help noticing important developments. Now that two thirds of the states have passed or proposed tort reform, the significance of these efforts is clear: the insurance premiums are rising, the crisis is deepening, and in some states and in some specialties it has reached critical proportions. The reason is that the "reforms" consist of minor legal technicalities and cosmetic economic changes. The essence of the liability crisis has not been addressed.

We live in a climate of expanding defensive medicine: more CME, more tests, more consultation, more relicensing and recertifying. While these efforts improve the quality of care, they have no bearing on the crisis. The reason is simple. The cause of the liability crisis is not the deteriorating quality of American medicine. The crisis of this profession was generated in and by the legal-judicial system. It cannot be remedied by manipulating the medical profession. It can be corrected only by modifying the legal-judicial system, which obviously has not been done.

Most reforms include the increased policing of the profession: controlling the impaired and incompetent physician. This has also no bearing on the crisis. Our opponents emphasize this to perpetuate the impression that the medical profession is the cause of its own troubles.

The cause of our frustration is, of course, that we seek remedy by the traditional method, by going to the legislators. Most of these are our opponents and have the power to preserve the status quo. It is time to explore new avenues which were not tried, ignored or rejected in the past.

There is one way to improve our faltering defensive strategy. The practice of medicine was traditionally a biological-psychological-social science. But not anymore. During the last three decades, every diagnosis and treatment became legal acts. Yet, we do not teach medicine in the undergraduate and postgraduate systems as legal art and science. The standard of care is changing rapidly. A 20-year-old license is an outdated document. But neither organized medicine nor the licensing authority issues an updated binding standard of medical care. Many physicians object to such suggestions. But the hospitals have their standards spelled out. Nurses learn from texts "standards of nursing care." The anesthesiologists issue updated standards of some aspects of their specialty. In major centers the standards are fixed in protocols. The growth of this trend is inevitable.

But as mentioned, our crisis was generated in and by the legal-judicial system. The solution must be sought and found within that system. The medical profession seldom ventures into this unfamiliar and hostile territory. But the heart of the crisis is here obvious. The *frivolous suit* is the privilege of the American lawyer to drag innocent persons to court, to cause serious professional economic and emotional damage and suffering for the entire family. It is a true tort act. But it is protected by the bar associations and the courts, because this privilege represents immense power and even more profit for the legal profession. It can be exploited with impunity ad infinitum. Since court litigations are expensive, the insurance companies found it economical to pay the accuser to avoid

court appearances. If an innocent person must pay to a false accuser to avoid court battles, it represents a moral bankruptcy of the entire judicial system.

The *joint and several liability* means that all the defendants might be held liable for damages regardless of the extent of the fault. This means that a physician can be held liable even if he did absolutely nothing wrong as long as he has insurance and assets. Sounds absurd? Not in our legal system. It is immensely profitable for the attorneys.

The noble principle of *equal protection before the law* is all but nonexistent. If the standard of care, its violation and the compensation are not stated by law, even similar cases will lead to different liabilities. We lack sharp definitions between plain accident, unavoidable bad result, unintentional mishap, true negligence, etc. Often we pay insurance premiums for Acts of God. The murky mixture of an inexact biological science and the black-and-white statement of attorneys allows the aggressive trial lawyer to shape "justice" for his personal benefit. The attorney has the freedom to manipulate judge and jury intellectually and emotionally in a subjective atmosphere, while liability will be determined ex post facto. The more skilled manipulator will get the larger award. The specialized attorneys of a large law firm can provide a "more equal justice."

But there are other dubious practices. If a pregnant woman uses drugs and damages the fetus, she is liable for nothing. If the physician's care can even remotely be linked to a damaged child, he can be held liable.

Take another example. If a private physician commits an error, he can be sued for every penny he has. If he commits the same error while working for the government at any level, he is liable for nothing by claiming sovereign immunity. The Constitution has never granted such immunity for the government. But our leaders assumed the privileges of King George as an absolute protection from human fumbling, errors and caprice of nature. It is our inevitable conclusion that profitability and not equality is the supreme principle of our system. We are dealing with the financial exploitation of a prosperous and vulnerable profession which did not prove to be a match for the trial lawyers. Often there is no more pretension of justice. It is all for profit.

The laudable principle of *right to speedy trial* is even in worse shape. If something goes wrong in the operating room, an expert panel can determine the facts usually within hours or days. The truth will not be more truthful eight years later. However, those eight years will multiply the income of the legal-judicial establishment by stretching the profitable years ad infinitum by legal technicalities.

These practices sound bizarre to anyone with any sense of social justice. Such practices are not part of the judicial system of any country, civilized or otherwise. They are not part of the Magna Carta or the U.S. Constitution. Ours is the only system which is dominated by the profit motive. The explanation is not difficult. The legislative bodies in Washington and in most state capitals are dominated by attorneys who also hold major administrative offices. They maintain their ties with their law offices to which they might return after the next election. They have full control of the legislative process. Their brothers on the bench, members of the same bar association, can never be truly impartial. The attorneys can shape the laws to their own interest and oppose anything endangering their liability income worth billions. In addition to control of the legal-judicial process, the attorneys can practice their profitable profession with impunity, claiming immunity as members of the court and government. Ask any court or lawyer. They will tell you that this is all legal and constitutional. How is this possible in the United States?

It is simple. The contradiction is built into the system. It was legal and constitutional a little more than two decades ago to refuse the admission of a black child to a white school. It was possible as long as the ruling establishment had the power to force the legal and constitutional label on anything in its own interest. Similarly, the current liability crisis cannot be solved by the enacted or proposed niceties but by addressing the essence of the problem. We must demand an impartial administration of an impartial law and end the profit oriented grip of the legal-judicial establishment on the liability billions which, in the humble opinion of this student of the Constitution, is legal but unconstitutional. We are dealing here with fundamental constitutional problems.

It is time that organized medicine petition the U.S. Supreme Court to issue an opinion on the constitutionality of the current liability practices:

1. A physician can be held liable even if he did nothing wrong (current practice);
2. He can be falsely accused, libeled and damaged for profit (current practice);
3. The rules of liability can be established in courts ex post facto (current practice);
4. The medical profession is not entitled to equal protection before the law (current practice);
5. Delaying the judicial process for profit of the legal establishment is acceptable (current practice);
6. If the attorneys in the legislative process pass laws for their own benefit, that is not a conflict of interest (current practice).

If the U.S. Supreme Court declares that these are constitutional practices, so be it. After all this is the bicentennial celebration of that document.

James Scott, M.D.
Streator, Ill.

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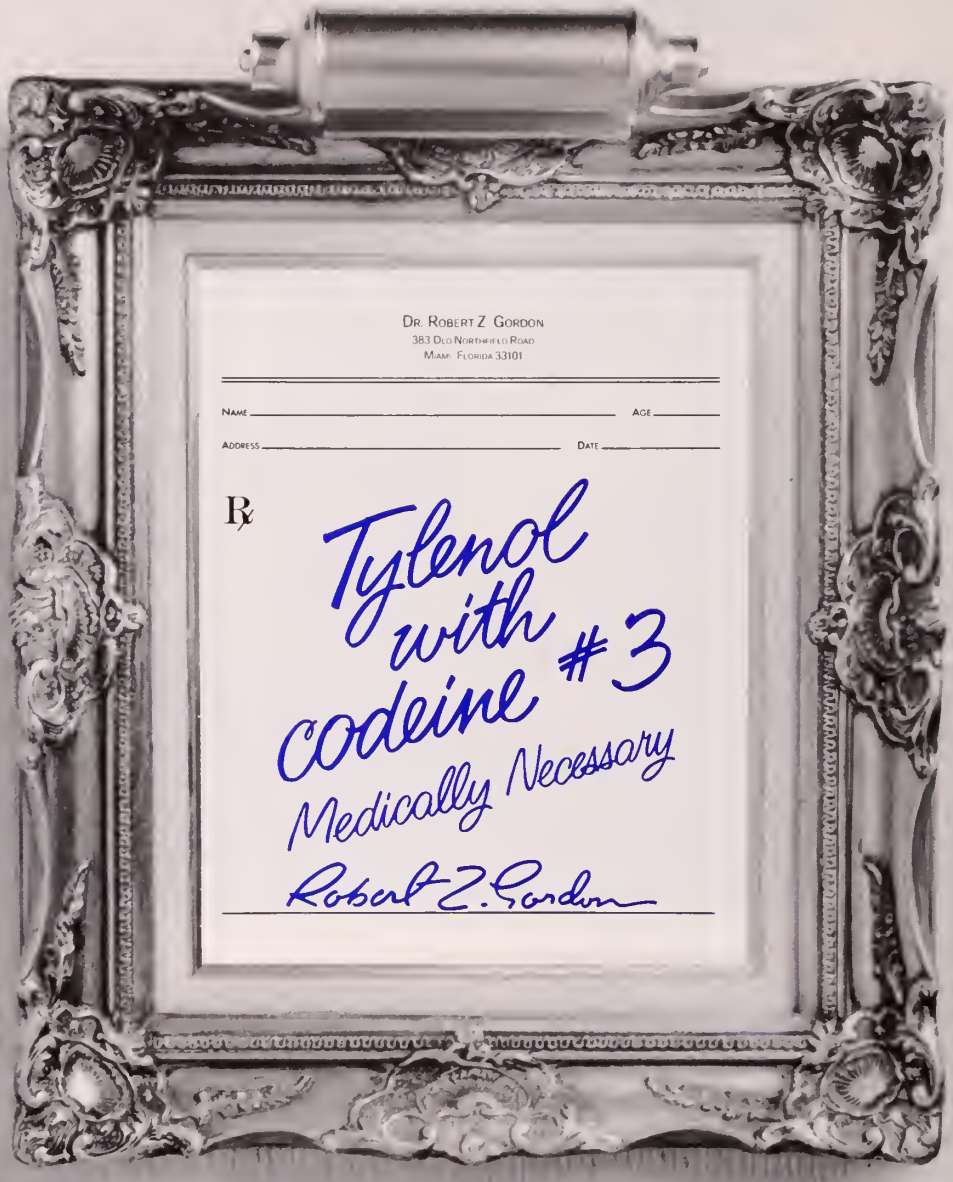
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Human immunodeficiency virus testing: The Palm Beach County alternative test site experience

Suzanne E. Landis, M.D., M.P.H., Dale Tavris, M.D., M.P.H., and Norma J. Allred, R.N., M.S.N.

ABSTRACT: Alternate test sites (ATSs) providing free, anonymous human immunodeficiency virus (HIV) antibody testing and counseling have been in operation in Palm Beach County (PBC), Florida, since June 1985. Of the 671 people who volunteered for testing, 128 (19%) were seropositive. The majority of persons tested were 20 to 39 years of age (80%); male (83%); white (95%), and male homosexual/bisexual (61%). Characteristics associated with seropositivity included: younger age (mean 32 years); male gender; black or Hispanic; presence of certain symptoms such as weight loss, swollen glands, or white tongue; risk groups of male homosexual/bisexual nonintravenous (IV) drug user or Haitian immigrant. ATSs in PBC, Florida, screen more homosexual/bisexual males and fewer IV drug users and Haitians than the risk proportions of reported AIDS cases would suggest. Efforts to enhance education and screening in this population should be a community priority.

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The acquired immunodeficiency syndrome (AIDS) is probably the most serious current public health problem facing scientists and public health officials.[1,2] In the absence of an available effective vaccine or specific therapy for the treatment of AIDS, broad-scale prevention and control activities must involve risk reduction programs that focus on appropriate behavior changes in an effort to reduce transmission of human immunodeficiency virus (HIV). An effective tool to determine who is at most risk of transmitting the virus is the enzyme-linked immunosorbant assay (ELISA) test to detect antibodies to HIV; this test was originally licensed by the U.S. Food and Drug Administration to screen blood and plasma collected for transfusion or manufactured into other products.[3]

The ELISA test has a high sensitivity of 99.3%, yielding a positive result in a high proportion of persons who actually have HIV infection and a high specificity of 99.8%, yielding a negative result in a high proportion of those who do not have the infection; thus, it is useful for both screening purposes as well as for differential diagnosis of clinical illness.[3-5] Almost all infected asymptomatic persons can be detected with the exception of those who have viremia without antibodies and possibly recent seroconverters with a low titer of antibodies.[3]

In an effort to shunt high risk people for AIDS away from the voluntary blood donation service, the Centers for Disease Control (CDC) requested 55 state and local health departments to provide alternate test sites (ATSs) where any individual could receive HIV antibody testing.[6] These ATSs are able to provide anonymous HIV antibody testing, appropriate pretest counseling, post-test counseling, and referral for medical evaluation, if indicated.[6] Notification of seropositive status may serve to control the spread of

HIV by encouraging self-deferral of blood donation, encouraging changes in sexual practices and providing circumstances for optimizing the health and well-being of the seropositive person.[7,8] Education about the natural history of HIV infection, and the meaning of a positive test result, advice on behavioral changes that will protect one's partner(s) from infection, and referral to additional resources are important components of the ATS services. As of September 1985 at least one ATS had been established by 52 of the 55 project areas with 21,200 persons having been tested.

In May 1986 the CDC published a preliminary report about the national ATS experience including number of sites per state, number of individuals presenting for testing, and the number of seropositive individuals.[6] By the end of 1985, 23 sites for HIV testing had been established in Florida, the ATSs had actually tested 5,811 persons of whom 21.4% were seropositive.[6]

Very few of the ATSs routinely collect information from their clients about sociodemographic variables, risk factors or symptoms of HIV infections. From the start of HIV antibody testing, Palm Beach County, Florida, has systematically collected information on all persons requesting screening. We report here the experience with the ATS screening program from June 1985 to September 1986. Are the screened persons in the high-risk-for-AIDS groups? Do they have any symptoms of HIV infection? Do they perceive an exposure to HIV? And are the characteristics associated with seropositivity in this group similar to what has been reported for AIDS cases in Palm Beach County, Florida?

Methods • Palm Beach County, Florida, has a cumulative incidence of 440 per million population, based on the number of AIDS cases diagnosed by March 19, 1987, and the 1980 census data. Compared to the 79 per million population incidence of AIDS in Elsewhere, USA (outside of known high incidence areas of over 1,000 cases per million population in New York City, San Francisco, and Miami) Palm Beach County has a substantially increased incidence. Four ATSs were opened in June 1985 by the health department and were available to everyone living or visiting in the county who was interested in knowing their antibody status. Each site designated specific hours of operation between 8 a.m. to 5 p.m. Monday through Friday. A donation of $20 was requested to be placed in a box as the person left the ATS. Measurement of antibody status was determined by an ELISA test (Abbott, N., Chicago, Ill.); doubly reactive positive tests of low titer were confirmed by a Western blot before recording the result as positive.

Before each person had his or her blood tested, a trained nurse administered a short questionnaire requesting age, gender, county and state of residence, marital status, occupation, income, risk behavior

Table 1.—Characteristics of Persons Volunteering for HIV Antibody Testing in Palm Beach County, Florida, June 1985 to September 1986.

Characteristics	HIV Seropositive Persons (N=128)	HIV Seronegative Persons (N=543)
1. Mean age (in years)*	32	35
Range (in years)	19 to 80	17 to 88
2. Gender % male*	92	81
3. Race**		
% Black	9	4
% Hispanic	2	0.2
4. Marital Status †		
% Single	53	55
% Married	11	17
% Living together	27	14
5. Occupation		
% Professional	16	19
% Construction	5	6
% Clerical	5	4
% Trade	31	25
% Unemployed	9	8
6. Income		
% ≥ $21,000	26	38
7. Source of referral		
% Media	32	36
% Friend, professional	76	70
8. Perception of exposure to HIV (%)	65	60
9. Fearful of test results (%)	41	42
10. Understand meaning of a positive HIV test		
% Correct answer	66	64
11. Symptoms (%) ‡		
Tiredness	27	24
Fever	12	11
Weight Loss*	13	6
Swollen glands*	28	10
Purple rash	4	3
Cough	9	5
Diarrhea	13	11
White tongue*	12	4
Bleeding	2	3
Bruising	2	7
Shortness of breath	11	8
12. Risk factor (%)		
Homosexual/bisexual men and intravenous (IV) drug users	4	1.5
Homosexual/bisexual men who are not IV drug users*	77	54.5
IV Drug users, heterosexuals	6	6
Hemophiliac	0	1
Transfusion recipient	1	4
Haitian or Caribbean immigrant since '79*	5.5	19
Prostitutes	0	0.4
Heterosexual contacts of high risk person*	5.5	19
None of the above	1	13
13. Number of high risk sexual* contacts (mean)	116	60

*$p \leq 0.005$ between seropositive and seronegative persons
**$p = 0.02$
† % in each column totals more than 100% because some people complained of more than one symptom.
‡ person who is single and living with someone is categorized as "living together."

Table 2.—Seropositive and Seronegative Persons by Age Group, Palm Beach County, Florida, Alternative Test Sites, June 1985 to September 1986.

Age Group	HIV Seropositive Persons Number	%	HIV Seronegative Persons Number	%
<13 years		0		0
13-19	1	(1)	8	(1.5)
20-29	56	(44)	198	(36)
30-39	55	(43)	200	(37)
40-49	10	(8)	65	(12)
Over 49	4	(3)	63	(12)
Unknown	2	(1)	9	(1.5)
Total	128	(100)	543	(100)

Chi square = 12, p = 0.035

status (yes/no answers to homosexual, bisexual, intravenous drug user, prostitute, Haitian or Carribean immigrant since 1979*, hemophiliac, sexual contact of one of the above), number of lifetime sexual contacts, present symptoms (yes/no to tiredness, fever, weight loss, swollen glands, purple rash, cough, diarrhea, white tongue, bleeding, bruising, and shortness of breath), source of referral to the ATS, perceptions of exposure to the virus, and degree of fear about a positive test result. Each person was identified by a client number printed on both the lab slip for the antibody test and on the questionnaire. All those tested were instructed to return in two weeks for their test results. A total of 800 people were tested from June 1985 to September 1986 and 671 people returned for their antibody results. Based on these results and the individual's risk behaviors, the nurse counseled the patient according to a revised CDC guideline (an Appendix is available from the authors upon request).

Summary statistics with frequency distributions, means, and proportions were computed for each variable. The student's t-test and chi square analyses were used to compare differences in the seropositive and seronegative groups for each variable of interest.

Results ● Of the 671 persons who comprised the study population, 128 (19%) were repeatedly seropositive by ELISA testing and Western blot testing while 583 (81%) were seronegative. The majority of persons being tested were: (1) within the ages of 20 to 39 years (80%); (2) male (83%); (3) white (95%); and (4) homosexual/bisexual males (61%).

As seen in Table 1, the seropositive persons as compared to the seronegative persons were significantly: (1) younger; (2) more likely to be male; (3) more often black or Hispanic; (4) more likely to have certain symptoms such as weight loss, swollen glands, or white tongue; (5) more likely to be a male homosexual/bisexual nonintravenous (IV) drug user or a Haitian immigrant; (6) less likely to be a heterosexual contact of someone in a high risk group; and (7) more likely to have a greater number of lifetime high-risk sexual partners. The seropositive persons were more likely to be in the age groups 20 to 39 years as compared to the seronegative persons ($p=0.035$); the range by age groups is shown in Table 2.

Other demographic factors such as marital status, occupation and income were similar in the seropositive and seronegative groups. Persons in both groups had a similar understanding of the meaning of a positive AIDS test, expressed similar perceptions of exposure to the virus and felt equally fearful of a positive test result. Among those who were seropositive 65% felt they had been exposed, 28% did not feel exposed, and 7% did not know if they had been exposed. Persons who did not return for their test results did not differ substantially from the persons who returned for their test results.

The presence of any one of 11 symptoms was signficantly associated with seropositivity (Table 3, $p=0.007$). A higher proportion of seropositive persons have symptoms than do the seronegative persons. As the number of symptoms increase above one, the proportion of persons who are seropositive increases slightly but no actual dose response phenomena is noted, perhaps because of small numbers.

Among the seropositive persons who had no concomitant intravenous drug use or transfusion history ($N=107$), 90.7% reported homosexual sexual contact, 3.7% claimed sexual contact with a person who used intravenous drugs, 2.8% had contact with prostitutes, and 2.8% had sexual contacts with Haitians.

The proportion of seropositive persons from the ATS screening in each of the CDC identified risk groups is different than the proportion for AIDS cases in Palm Beach County[9] (Table 4). A higher proportion (92%) of men are seropositive in the ATS as compared to the AIDS cases (84%). Of the seropositive persons in the ATSs, almost all are homosexual/bisexual males (81%) as compared to 40% of the AIDS cases. Our ATS population contained fewer persons with hemophilia, IV drug users, and Haitians; it also contained no children.

Discussion ● In general almost 90% (598/671) of the persons appearing for anonymous, voluntary HIV screening in Palm Beach County, Florida, are in one of the following high-risk-for-AIDS groups: (1) homosexual/bisexual men and IV drug abusers; (2) homosexual/bisexual men who are not IV drug users; (3) IV drug users, heterosexuals; (4) transfusion recipients; (5) Haitian or Caribbean immigrant since 1979; (6) prostitutes; (7) heterosexual contacts of one of these groups. The seroprevalence in the Palm Beach County, Florida, ATS population is 19% as compared to 0.04% among blood donors in 1985.[10]

* At the time this questionnaire was written, Haitians were considered a high risk group.

Table 3.—Results of HIV Antibody Test by Presence of Symptoms.

Result of HIV Antibody Test	No Symptoms No.	% in col.	Any Symptoms No.	% in col.	Total No.	% in row
Negative	322	(85)	221	(76)	543	(81)
Positive	59	(15)	61	(24)	128	(19)
Total	381	(100)	290	(100)	671	(100)

p = 0.007
Chi square = 7.4

Table 4.—Comparison of AIDS Cases to Seropositive Persons Indentified Through Alternate Test Sites in Palm Beach County, Florida.

Characteristics	Palm Beach Cnty AIDS Cases (N=257)	Seropositive Persons From ATSs (N=138)
1. Gender		
% male	84	92
2. Risk factors		
% Homosexual male	40	81
% IV drug user	17	6
% Hemophilia	1	0
% Transfusion	2	1
% Haitian	18	5.5
% Prostitute	0	0
% Heterosexual contact	8	5.5
% None known	11	1
% Infant*	3	0

* No infants were checked at ATSs

Very few drug users volunteered for testing. This may reflect a true underrepresentation of drug abuse in Palm Beach County or more likely may reflect a social phenomenon where drug users do not seek knowledge of their antibody status. Hemophiliacs generally are followed medically for their primary disorder and have ready access to HIV antibody testing through their primary care providers. It is, therefore, not surprising that very few hemophiliacs came in for testing at an ATS.

Whereas 84% (107/128) of our seropositive persons from the ATSs reported sexual contact as the most likely source of exposure, 64% (40% homosexual, 18% Haitian, 8% heterosexual contact) of the AIDS cases from Palm Beach County report this type of contact. Homosexuals or other sexually active persons may be more health conscious, may be more likely to personally know someone with AIDS due to the strong community social networks and, thus, might be more likely to volunteer for HIV antibody testing.

A large percentage of persons presenting for testing had at least one symptom (290/671, 43%). Membership in a high-risk-for-AIDS group may not be the sole reason a person volunteers for testing, whereas the presence of symptom(s) may be an additional stimulus for seeking the antibody test.

The persons who volunteered for HIV antibody screening tend to be in the same age groups with the highest incidence of AIDS, perceive a specific exposure to HIV, hear about the test most often from a friend or health care professional, and may have symptoms associated with AIDS.

The data presented suggest that most of the people tested have symptoms and think that they have been exposed to HIV. We do not know how many other high risk people without symptoms have also not appeared for testing.

Heterosexual contacts of a high risk person for AIDS comprised a higher proportion of the seronegative group (19%) as compared to the seropositive group (5%). Most of the seropositive persons are included in the homosexual/bisexual group, whereas more of the seronegative persons are heterosexuals, with or without other risk factors for AIDS. A positive HIV antibody test occurs in this heterosexual contact group although in a smaller percentage than with the other known risk factors.

Recent Haitian immigrants tested at the ATSs had extremely high (67%) seroprevalence rates for HIV although this percentage is based on small numbers. Palm Beach County has a large population of Haitians; many of them have tested positive in the western part of the county.[11] Haitian and IV drug users both account for 18% each of the AIDS cases here. Therefore, we suggest that public health officials should specifically target these two high-risk populations for education and testing.

If the goal of these alternate test sites is not only to protect the blood system but also to provide an anonymous site for HIV testing, we should try to reach all those practicing any high risk behavior for AIDS. The CDC has tried to publicize that membership in a high risk group is, in and of itself, enough to warrant changing risky behavior and getting the antibody test.[6,9] Public health personnel hope that knowledge of serologic status and appropriate counseling will:

(1) stimulate seropositive persons to alter high risk behavior in order to reduce transmission of HIV and to prevent reexposure to HIV; and (2) encourage seronegative persons to also reduce their high risk behavior to prevent future seroconversion.

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Perspective on chemotherapy for cervical cancer

John J. Kavanagh, M.D., F.A.C.P.

ABSTRACT: Chemotherapy for recurrent or metastatic carcinoma of the cervix is part of the overall management of a patient. After insuring adequate pain control, palliative radiotheraphy and social support consideration is given to the use of antineoplastic drugs. The most effective drug is cis-platin given at a dose of 50mg/m² IV every 3-4 weeks. Combination chemotherapy at present remains unproven. Remissions occur in approximately 20-40% of patients, lasting several months. A small percentage of patients will have excellent prolonged complete remissions. Patients with extra pelvic metastases are more likely to respond than those with recurrences in a radiated field. Future efforts should concentrate on the development of newer agents.

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Chemotherapy for disseminated or recurrent cervical cancer presents a difficult task. Although several types of malignant disease are noted for their sensitivity to chemotherapeutic drugs, cancer of the cervix is not among them. This absence of sensitivity has been attributed to several factors. The first is the primary resistance of the tumor type itself. In general, squamous cell cancers in other parts of the body are not sensitive to chemotherapy. The reason may be that the majority of chemotherapeutic drugs are most effective on rapidly growing tumors and squamous cell cancers have a slow growth rate. Our knowledge is limited about the drug sensitivity of adenocarcinomas or small cell carcinomas of the cervix.

A second factor is previous treatment of the tumor(s) with radiation therapy. Irradiation is thought to decrease vascularity and to limit delivery of the drug to the malignancy.

A final factor is the performance status of the patient at the time she begins chemotherapy. Often, pelvic recurrences of cervical cancer will cause obstructive uropathy, infection, bleeding, and inanition and with these conditions, patients tolerate chemotherapy poorly.

In treating patients who have recurrent cervical cancer, the major emphasis is on palliation. Localized lesions may be treated best by radiation therapy. The judicious but generous use of analgesics for the relief of pain is encouraged. In patients who have pelvic disease recurrences, large doses of these medications given around the clock are frequently necessary. In the patient who has asymptomatic distant metastases, observation alone may be the best course of treatment. If pelvic exenteration is not possible in a patient and if radiation therapy has been exhausted, then the treatment will correspond to the

degree of symptomatology. Chemotherapy is reserved for the patient who has increasing systemic tumor burden that is not amenable to local palliative therapy.

Single agents ● A large variety of chemotherapeutic agents have been tried for treating cancer of the cervix. Drugs most commonly used are vincristine (Oncovin), bleomycin (Blenoxane), mitomycin C (Mutamycin), and cisplatin (Platinol). Response rates are usually in the range of 10 to 40% partial remissions, partial disappearance of malignant disease. The remissions usually last about three to six months.

Vincristine, a derivative of the periwinkle plant, has been used to treat cervical cancer in small numbers of patients. This compound's major advantages are its lack of myelotoxicity and the minimal associated nausea and vomiting. The major problems are neurotoxicity and constipation. Activity of this drug is marginal against cervical cancer and its role in combination therapy is questionable.

Bleomycin is an antibiotic produced from *Streptomyces verticillus*. The drug, which causes multiple breaks in DNA, is considered to have maximal effect in the G_2 phase of the cell cycle and is fairly well tolerated with mild fever and chills being the most frequent side effects. If the patient has fever for a prolonged period, pulmonary fibrosis may result. Myelosuppression is minimal with this compound. Initially a high response rate was reported in patients with squamous cell carcinomas; however, later responses have not been confirmed. A modest response rate of 10 to 20% appears more reasonable.

Mitomycin C, a purple substance isolated from the bacterium *Streptomyces caespitosus*, is considered to be an alkylating agent that causes cross-linkage of DNA chains. The drug is well tolerated during administration; however, it does cause tissue damage if extravasation occurs. The major problem encountered, particularly with cumulative doses, is myelosuppression. Leukopenia and thrombocytopenia may persist for weeks after completion of therapy. The drug's activity has been reported mainly in combination regimens. Although mitomycin plays a role in these regimens, its true additive component is unknown. If the drug is used at all in the treatment of cancer of the cervix, it should be with caution because of the possible cumulative problems involving neutropenia and thrombocytopenia.

Cisplatin is a unique chemotherapeutic compound discovered serendipitously after observation of elongated growth patterns of bacteria in a complex culture medium. Eventually it was isolated as the active substance. The drug, which has been well tested in patients with cervical cancer, has a response rate clearly better in those who have not been exposed previously to chemotherapy. The Gynecologic Oncology Group reported a 38% total response rate that lasted about five to six months. There is no clear relationship between cisplatin dosage and degree of response to the drug, i.e., 50 mg/m^2 intravenously given every 21 days is equally as effective as are higher doses. It should be noted that long-term complete responses, although gratifying, are still distinctly unusual.

Combination chemotherapy ● Numerous combination therapy regimens for cervical cancer have been reported in the literature.[1,4] It is difficult to ascertain which one is the most effective for several reasons. First, the impact of such a regimen on survival of the patient population as a whole is usually marginal. Often survival is not even reported in the study. Second, most studies are not designed to compare single agents with combination regimens. Third, patients are not stratified according to prognostic factors, particularly performance status, renal failure, and extrapelvic metastases. A further problem is the fact that different investigators have achieved varying results using the same regimen.

Combinations that involve bleomycin and mitomycin C have been reported in several studies with patient response rates ranging from 16 to 65%. Myelosuppression, mucositis, and pulmonary toxicity were the side effects seen in all studies. As more patients were treated with these two drugs, the overall response rate was in the range of 20 to 40%. However, it was again noted that for the vast majority of patients, the median duration of response was only a few months.

The introduction of cisplatin has led to combination chemotherapy regimens using vincristine, bleomycin, and mitomycin C. This potent group of agents initially was reported to have a 50% response rate against cervical cancer. Of significance was the high number of complete responses including two patients who were in remission for over two years. However, a larger study that compared the same combination with and without cisplatin yielded inferior results.

Arterial infusions ● For over 20 years, there have been attempts to infuse chemotherapy agents directly into tumors of the pelvis. Catheters were placed either surgically or by percutaneous methods. It is clear that objective responses did occur with a broad range of drugs. Responses were particularly dramatic in patients who had no prior radiation therapy. However, what is not clear is the ultimate benefit to the patient in terms of survival and improvement in the quality of life. There may be a role for this therapy in the treatment of larger cancers of the cervix prior to irradiation. At present, the role of arterial therapy is uncertain and will depend on the development of more active agents.

Radiation sensitizers ● In the laboratory, there is substantial evidence that chemotherapeutic agents such as hydroxyurea (Hydrea) and doxorubicin

(Adriamycin) make dividing cells more sensitive to the destructive effect of radiotherapy. Two studies that involved the use of hydroxyurea during radiation therapy for cervical cancer both reported an improvement in patient survival. The therapy combination was well tolerated. This promising finding deserves further investigation.

Summary ● Chemotherapy for the treatment of carcinomas of the cervix requires clinical judgment. The general treatment orientation should be one of palliation. If the patient is asymptomatic, has minimal tumor burden, and is not a candidate for pelvic exenteration, then observation is in order. Patients with localized painful tumor recurrences should be treated initially with radiotherapy. The narcotic requirements of these patients may be high and an aggressive pain-management program is essential. Chemotherapy should be initiated in the patient who has advancing tumor burden with systemic symptoms. The exact combination of drugs to be used in such cases is conjectural. Usually the treatment involves bleomycin, mitomycin C, vincristine, or cisplatin. Some investigators favor utilizing methotrexate and doxorubicin. Responses occur in 10 to 50% of patients, are usually partial, last a few months, and manifest during the first two cycles of chemotherapy. Occasionally there may be a gratifying complete response that continues for many months. In such cases the duration of treatment is very uncertain but should probably be for no more than six cycles if there is no evidence of progressive disease. Patients who fail the standard chemotherapy regimens may be offered a trial of investigational agents.

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Virilizing thecoma: case report

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ABSTRACT: Functional ovarian tumors are generally of a stromal or "sex cord" origin. Thecomas arise from mature ovarian stroma and the cells resemble theca cells. These tumors are almost never malignant, usually are unilateral, and are seldom seen prior to puberty. Their clinical manifestation is generally estrogenic although occasionally virilism is seen. This paper presents the case of a young black female with delayed menarche and a virilizing fibrothecoma.

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A 17-year-old virginal, black female presented to the clinic of University Hospital of Jacksonville with the persistent complaint of primary amenorrhea. On her initial visit in 1982 she had normal secondary sexual characteristics and stated that breast development began at age 11. At age 14, an evaluation for amenorrhea was conducted. Thyroid studies, gonadotropins and prolactin levels were found to be normal. She appeared normal on physical examination. To evaluate the competence of the uterine outflow tract, she was given medroxyprogesterone acetate 5 mg daily for five days. She had no withdrawal bleeding after the progestin. Subsequently, she was given two trials of conjugated estrogens 1.25 mg daily for 21 days along with the administration of medroxyprogesterone 5 mg for the last five days. Prior to estrogen administration, an endometrial biopsy showed only fragments of glandular epithelium. Repeated pelvic examinations were unremarkable. Repeat gonadatropins, TSH and prolactin were normal. She reported spotting after the second course of estrogen/progestin therapy. This was interpreted as a withdrawal bleed and the patient was diagnosed with delayed onset of menses. At age 17, she returned with the persistent complaint of amenorrhea. At that visit, facial hirsutism was noted along with a husky voice which the patient interpreted as hoarseness and cliteoromegaly. Pelvic examination disclosed a 12 cm x 10 cm solid pelvic mass in the cul de sac. Papanicolaou smear noted poor estrogenic effect and Class I cytology.

Laboratory profile revealed the dehydroepiandrosterone sulfate level to be 266 ug/dl. Radioimmunoassay for total serum testosterone measured at 2.36 ng/dl. An intravenous pyelogram exhibited normal renal system with lateral displacement of the left distal ureter.

On laparotomy, she was found to have a 16 x 10

x 5 cm tumor replacing the left ovary. The surface was nodular and irregular. The tumor and left adnexa were removed. Frozen section revealed a fibrothecoma. The right ovary appeared normal except for one small nodule at its lower pole that grossly appeared calcified. A biopsy was taken of the nodule.

When sectioned, the tumor had several small areas of cystic degeneration. The color varied between whitish-yellow to grey. The microscopic appearance showed large vacuolated pale cells, theca cells, with bands of fibrous tissue separating nests of theca cells. Scattered small foci of calcific densities were noted. The biopsy of the right ovary exhibited mild stromal thecosis and focal calcification similar to features seen in the fibrothecoma of the left ovary.

Postoperative course was unremarkable. Six weeks past removal of the tumor, she had a testosterone level of 27 ng/dl. She reported her first spontaneous menses four weeks after tumor removal.

Discussion ● Fibrothecomas are ovarian tumors which are primarily benign and arise from mature ovarian stroma. Although these tumors are often described separately, they may be understood more easily if thought of as a spectrum. On one end is the fibroma in which fibroblasts predominate while at the other end the thecoma contains endocrine appearing cells.[1] Indeed, some researchers believe that the continuum extends beyond thecomas to luteinized thecomas, lipid cell thecomas, and lipid cell tumors. It is believed that all these tumors form a series of related stromatogenous tumors with increasing functional properties along the spectrum.[2]

Ovarian fibromas are solid tumors that when sectioned have a chalky-white surface which has a whorled appearance. Focal calcification is occasionally present. Microscopically they are composed of spindle cells forming collagen.

The thecoma is composed almost entirely of pale vacuolated lipid-rich cells that resemble theca cells. They are firm fibrous tumors typically yellow or orange. The more common forms have theca cells interlaced by a fibromatous component. Another form, called luteinized thecomas, have leutin cells scattered in nests throughout the tumor. Some authors believe that the luteinized thecomas may actually be Sertoli-Leydig cell tumors that do not happen to contain crystalloids of Reinke.[3] There is also the fully luteinized form called a stromal luteoma which is included in the lipid cell tumor category for purposes of differential diagnosis.[4]

Thecomas most often are accompanied clinically by estrogenic manifestations. This clinical presentation is somewhat paradoxical when considered in light of the two cell theory of steroid production in the ovary, i.e., the theca cells produce androgens which are aromatized to estrogens by the granulosa cells.[5] Virilizing fibrothecomas have been reported,[5] but more often the virilizing forms are luteinized thecomas or luteomas of pregnancy. Luteinized thecomas have leutin cells scattered in nests throughout the tumor. These tumors have androgen effects in approximately 10%.[6] Luteomas of pregnancy are responsive to HCG and may cause virilization in the infant as well as the mother.

Hirsutism is the most sensitive marker of increased circulating androgens, which are primarily testosterone. Acne, menstral irregularities, clitormegaly and masculinization of body habitus, hair patterns and voice follow. The diagnostic workup for hyperandrogenism essentially involves determining the source of the excess androgen. The sources of androgens are the adrenals and the gonads. Adrenal causes of hyperandrogenism can most often be excluded by measuring the serum level of dehydroepiandrosterone sulfate (DHAS). Ninety-five percent of this steroid is produced by the adrenal gland. If the circulating DHAS level is less than 700 ug/dl an adrenal source of the hyperandrogenism is most unlikely.[7] The other androgen to be measured is serum testosterone. If the total testosterone level is greater than 200 ng/dl a tumor should be suspected.[7,8] In the present case, diagnosis of the pelvic tumor with a normal DHAS measurement and increased testosterone level of 266 ng/dl made an ovarian tumor the obvious cause of virilization and amenorrhea.

Virilizing fibrothecomas although unusual have been reported but they are extremely rare as a cause of primary amenorrhea. The mechanism of the amenorrhea in hyperandrogenism has been shown to be caused by disruption of gonadotropin secretion.[6] In this patient, removal of the tumor resulted in lowering of the circulatory testosterone and the appearance of the first spontaneous menses approximately four weeks later.

Summary ● This is a report of an unusual presentation of a virilizing fibrothecoma which caused primary amenorrhea and virilization in a 17-year-old patient. The amenorrhea resolved after the tumor was resected.

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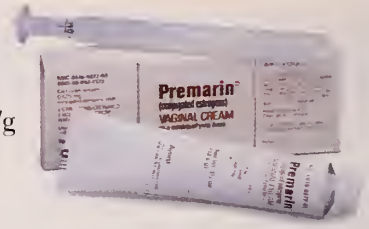
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1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA
Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.
2 ESTROGENS SHOULD NOT BE USED DURING PREGNANCY
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:
a. Increased sulfobromophthalein retention.
b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.
d. Impaired glucose tolerance.
e. Decreased pregnanediol excretion.
f. Reduced response to metyrapone test.
g. Reduced serum folate concentration.
h. Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, premenstrual-like syndrome, amenorrhea during and after treatment, increase in size of uterine fibromyomata, vaginal candidiasis, change in cervical erosion and in degree of cervical secretion, cystitis-like syndrome, tenderness, enlargement, secretion (of breasts), nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice, chloasma or melasma which may persist when drug is discontinued, erythema multiforme, erythema nodosum, hemorrhagic eruption, loss of scalp hair, hirsutism, steepening of corneal curvature, intolerance to contact lenses, headache, migraine, dizziness, mental depression, chorea, increase or decrease in weight, reduced carbohydrate tolerance, aggravation of porphyria, edema, changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only:* For treatment of moderate-to-severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Osteoporosis: Female castration: Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only: For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.
Administration should be cyclic (eg, three weeks on and one week off).
Attempts to discontinue or taper medication should be made at three- to six-month intervals.
Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.
Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Lindsay R, Hart DM, Clark DM: The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. **2.** Studd JWW, Thom MH, Paterson MEL, et al: The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrus JL (eds): *The Menopause and Postmenopause*. Lancaster, England, MTP Press Ltd, 1980, chap 13.

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Florida neurosurgical lawsuit profile - 1987

John S. Boggs, M.D.

The Florida Neurosurgical Soeiety set about to gather information about lawsuits filed against its members. In 1987 insuranee rates reached record levels in Florida; $160,000* a year for one million/three million eoverage in South Florida, and $90,000* a year for eomparable eoverage in North Florida. St. Paul Fire and Marine Insuranee Company provided me with information indieating that in the years 1983, 1985, and 1986, over 50% of the neurosurgeons insured by the eompany had elaims against them.[1]

In an effort to deal with this situation, neurosurgeons reacted appropriately; some have moved out of the state and others retired early. Those who remain in praetiee have sought to limit their exposure to high risk liability situations. Neurosurgieal emergeney room coverage in eertain areas is limited only to a few trauma eenters. Most of us remaining in practiee have an inereasing list of procedures we no longer do because of the liability risk.

In trying to convey our situation to the legislators and task foree wrestling with this liability problem, a lack of faets and figures about neurosurgieal praetiee became evident. I eonstrueted the following lawsuit questionnaire to gather this information.[2] Two mailings to the Florida Neurologieal Soeiety membership were sent out six weeks apart, and 80 of the 111 physicians responded within three months, a fantastie 72%! The questionnaire is as follows, along with some of the pereentage of responses.

* As of July 1987, St. Paul Fire and Marine Insurance Company increased its premiums for physician liability insurance by 48% in South Florida and 22% in North Florida.

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LAWSUIT QUESTIONNAIRE

PHYSICIAN PROFILE:	RESULTS Percentage
Number of Year in Practice	
0 - 5	
5 - 10	
10 - 15	
15 - 20	
20 - 25	
25 - 30	
Over 30	
Location	
South	41.3
Central	32.5
North	12.8
West	7.5
Number of Suits in Florida _____	
Number of Suits 1983 to present: _____	
PLAINTIFF PROFILE:	
Age	
0-10	2.2
10-20	6.3
21-30	6.5
31-40	18.7
41-50	25.9
51-60	20.1
61-70	15.1
71-80	5.0

(continued)

Patient Origin

Emergency Room	43.0
Private	43.6
Clinic	2.7
Other	10.7

Patient Insurance Status

Indigent	18.0
Medicaid/CMA	.7
Private	47.0
Medicare	19.4
Other	14.4

Male / Female	51 / 49
LAWSUIT PROFILE:	RESULTS
(if more than one, duplicate the form)	Percentage

Site of Alleged Incident

E.R.	8.5
O.R.	54.2
Hospital Room or Floor	19.0
X-ray	8.5
Office	5.6
Other	4.2

Result of Suit

Won	23.8
Lost	11.9
Settled	43.6
Other (Dismissed)	20.8

If lost, amount awarded _____
$96,583 (Average)

_____ Economic Damages
_____ Non-Economic Damages

If settled, amount settled for _____
$187,217 (Average)

Defense Attorneys, Please give names:

Plaintiff Attorneys, Please give names:

Plaintiff Expert Witnesses, please give names:

_____ From Florida
_____ Outside Florida

Defense Expert Witnesses, please give names:

_____ From Florida
_____ Outside Florida

Alleged Injury Profile: Brief Description, please:

Time from Incident to Conclusion of Suit

1 - 2 years	29.3
3 - 4 years	11.0
5 - 6 years	53.7
7 - 8 years	3.7
Over 8 years	2.4

Was Incident Reported to Insurance Carrier In Advance of Notice of Suit (VIP INFO)

_____ YES	23.8
_____ NO	40.0

The questionnaire results reveal that 73.8% of neurosurgeons in the state have been sued. There have been 2.05 lawsuits per physician cumulatively and 1.36 lawsuits per neurosurgeon since 1983. Of the 20 neurosurgeons responding with no lawsuits, only two were located in South Florida (Table 1). Yet this area contains only 41.3% of the state's neurosurgeons. Only three neurosurgeons in practice over 20 years reported no lawsuits.

Table 1.

REGION	% OF FLORIDA NEUROSURGEONS	# WITH ZERO LAWSUITS
South	41.3	2
Central	32.5	10
North	13.8	7
West	7.1	1

Analysis of origin of patient filing a lawsuit is revealing. A whopping 43% came from the emergency room. This is much more meaningful than the oft-quoted statistic that seven to 12% of alleged incidents generating lawsuits occur in the emergency rooms. This bears out our long-held belief that the uncontrolled situation in the emergency room, with little time to establish patient rapport, is a high liability risk situation. This 43% is out of proportion to the percentage of emergency room patients a neurosurgeon sees in private practice, usually 10 to 20%. These facts alone identify the emergency room as a potentially high risk area for the neurosurgeon and indicate that need for special protection for the physician here in order to preserve neurosurgical emergency coverage. Neurosurgical emergency services have already been restricted to only certain hospitals in some parts of the state and this trend can only spread without measures to limit the liability caring for emergency patients.

The questionnaire seems to reveal that indigent patients are not more prone to file lawsuits than funded patients. Indigent patients accounted for 18% of the lawsuits. Private insurance and full-pay patients accounted for 47%. This would tend to dispel the idea that the patient unable to pay his bills due to indigent status is more likely to file suit to make up those financial losses.

The following pages list actual individual lawsuits, identifying details as best I could from the questionnaire (Table 2).

The type of alleged injury in these lawsuits shows some interesting trends. Two cases were related to aneurysm surgery complications reflecting a national increase in the liability of this particular surgery. Surprisingly, three suits arose from alleged injury during

Table 2.—Lawsuit Profile.

Physician	Case	Alleged Injury	Defense Attorneys	Plaintiff Attorneys	Plaintiff Expert Witnesses	Defense Expert Witnesses	Result of Case
1	A—E	Not specified	Dweyer Schwartz	Schlesinger	Not specified	Young Cramer	A-Settled $3750 B-Settled $12,000 C-Settled $25,000 D-Won E-Dismissed
2	A—H	Not specified	Not specified	Not specified	Not specified	Not specified	A-Settled $40,000 B—H-Pending
3	A—C	Myelogram Reaction	Foothill Wormac	Not specified	Not specified	Perlmutter	A-Settled $37,500
	B—C	Unspecified					B—C Dropped
4	A	Laminectomy Complications	Saeva	Blews	Gerol	Sweet Mellman	Won
5	A—D	Not specified	Not specified	Not specified	Not specified	Not specified	2-Won 1-Settled 1-Pending
6	A	Laminectomy Complications	Gibbon	Witzell	E. Walker	None given	Settled $10,000
7	A	Spinal Osteomyelitis	Unclear				1-Won 1-Settled $30,000
8	A	AVM Surgery	Rinamin	Terrell	Luessenhop	Tew	Won
9	A	Chemonucleolysis	Bernard	Spence	Fager	Not listed	A-Settled $575,000
	B—C	Chemonucleolysis					B—C-Pending
10	A	Disc Space Infection	Thron	Rood	Frazier	Not Listed	Pending
11	A	Laminectomy Infection	Hennen	Goldstein	Not listed	Not listed	Pending
13	A	Failure to Diagnose Hypoglycemia	Not listed	Not listed	Not listed	Not listed	Settled $1300
14	A	Not listed	Hill	Lloyd	Not listed	Not listed	Pending
15	A	Not listed	Not listed	Not listed	Not listed	Not listed	A-Dropped
	B	Not listed	Not listed	Not listed	Not listed	Not listed	B-Pending
16	A	Postop Intracerebral Hematoma	Handley	Vostre	Sidney Gross, M.D.	George Sypert, M.D.	Won
17	A	Phrenic Nerve Injury	Woodruff	Cunning-ham	Sidney Cohen	Ralph Rydell	A-Settled $7000
	B	Phrenic Nerve Injury	Deacon	Cunning-ham	Busey	Sweet	B-Won
	C	Quadriplegia, SCI	Deacon	Krupnick	Not listed	Not listed	C-Pending
18	A	Fall from Bed	Searcy	Schless-inger	Not given	Not given	A-Won
	B	Postsurgical Suba-rachnoid Hemorrhage	Patrick	Schless-inger	Not given	Not given	B-Settled $1000
	C	Missed Fractured Arm	Not listed	Not listed	Not listed	Not listed	C-Pending
19	A	Aneurysm Surgery Complication	Lynn	Spence	Pinkers	Unclear	Settled $500,000
	B—D	No information given					
21	A	Cervical Spondylosis Complication	Maxwell	Roth Grossman	Patricia Kline & McMurthy, Victor, Shafty	Brackett, Cooney, & Martin, Fager	Lost $1,400,000
	B	No information given					

Table 2.—Lawsuit Profile (continued).

Physician	Case	Alleged Injury	Defense Attorneys	Plaintiff Attorneys	Plaintiff Expert Witnesses	Defense Expert Witnesses	Result of Case
22	A	Corneal Ulcer, RF Sensory Rhizotomy	Not listed	Not listed	Not listed	Not listed	A-Pending
	B	Seizure Secondary to Water Deprivation	Not listed	Not listed	Not listed	Not listed	B-Pending
25	A	Complications of Cervical Disc	Harrell	Not listed	Not listed	Not listed	Dropped
	B	Blamed because of doing CPR	Not listed	Not listed	Not listed	Not listed	
26	A—C	No details listed					
27	A	Trauma Patient/ Hydrocephalus	Hartz	Kurzban	Wooding Cahill	Lustgarten	A-Settled $100,000
	B	Aneurysm Surgery Complication	Lundeen	Feola	LeClerg	Fleischer	B-Settled $40,000
	C	Trigeminal Rhizotomy Complication	McCoy	Not listed	Sheldon Weidner		C-Settled $25,000
28	A	Thoracic Ruptured Disc with Paraplegia	Bullock	Ward	Selby	Mayfield	Settled $15,000
29	A	Patient Died, Multiple Injuries	Mauro	Ostrow	Not listed	Not listed	Pending
30	A	Death from Cerebellar Abcess	Jones	Not listed	None	None	Settled $250,000
	B—D	No details given					
31	A	Cause - Not listed	Barker	Unknown	None	None	A-Suit Won
	B	Delayed Traumatic Intracerebral Hematoma	Blake	Jack Larkin	Charles Duncan, M.D. Sydney Gross, M.D.	Donald Long, M.D.	B-Settled $250,000
	C	Incorrect Diagnosis, Cerebellar Dysplasia	Cliff Somers	Dennis Hightower	Unknown	Unknown	C-Pending
32	A	Dilantin Overdose	Unknown	House	Balleguerra	Norrell	Unclear
	B	Wrong Level Laminectomy - Details Unclear					
	C—D	Details Unclear					
35	A	Paraplegia Following Cervical Spondylosis Surgery	Not listed	Gray	Jacque Schaerer	Not listed	Pending
36	A	Anterior Fusion Complication	Van-Gaasbeck	Roberts	Sidney Gross	George Sypert, Hoff, Holly	A-Won
	B	Untimely Diagnosis in Trauma - Details Unknown					
	C	Untimely Diagnosis of a Leg Fracture - No Details					B-Pending
	D	Wrongful Death Following Head Trauma	Van-Gaasbeck	Montgomery	Keedy, M.D. Weinberger, M.D., Morrell, Bernad, Spitz	Unclear	C-Pending
38	A	Not listed	Blake	Larkin	Duncan B. Sussman	Albright Don Long	Won

Table 2.—Lawsuit Profile (continued).

Physician	Case	Alleged Injury	Defense Attorneys	Plaintiff Attorneys	Plaintiff Expert Witnesses	Defense Expert Witnesses	Result of Case
39	A	Carotid Artery Injury in Transphenoidal	Jonnasen H. Gibbons	Greceo	Unknown	Unknown	Pending
40	A—F	Details not listed					
41	A	Retained Cottonoid	Not listed	Not listed	Not listed	Not listed	Lost $10,000
42	A	Unlisted	Hasty	Not listed	Not listed	Not listed	Won
	B	Inappropriate Indication for Tests	Unknown	Unknown	Unknown	Unknown	Pending
	C	No details					
43	A	Wrong Level Laminectomy	Saieva	Blews	Gerol	Mellman	Won
44	A	Fever Following Head Trauma	Blackwell Walker Gray	Not listed	Not listed	Not listed	Pending
	B—C	No details					
48	A	No details	Blackwell Walker	Not listed	Not listed	Not listed	A-Settled $19,000
	B	No details					
49	A	Failure to Operate in Thoracic Fx.	Taraska	Not listed	None	Sypert, Norrell	Dropped
51	A	Wrongful Death	Green	McGuire	Unknown	Unknown	A-Pending
	B	Complications of Meningioma Surgery	Green	Somberg	None	None	B-Settled $20,000
52	A	Complication of Thoracic Fracture, Failure to Operate	Taraska	Roberts	None	Sypert Norrell	Dropped
53	A	Wrong Level Chymopapain injection	Day, Lewis	Allen	Sood	Scharf	Settled $300,000
54		NOTE: 10 suits, 4 physicians, no details					
55	A	Foot-Drop Following Laminectomy	Gibbon	Witzell	Exum Walker	Padar	Settled $10,000
56	A	Lumbar Osteomyelitis Following Radiation for Neoplasm	Deacon	Lund	Not listed	Allen Miller	Settled $250,000
57	A	Cranial Perforator Complication	Hahn	Beltz	Unknown	Unlisted	Settled $1,000,000
58	A	Pulmonary Embolus Following Surgery	Unlisted	Unlisted	Schaerer	Sheffel	A-Pending
	B	Neurological Deficit Following Cervical Laminectomy, Details Unknown					B-Pending
59	A	Carotid Surgery Complication	Brannon	Bruce	Unlisted	Unlisted	Settled $37,000
60	A	Arterial Injury in Anterior Cervical Fusion, Details Unknown					A-Settled ? amount
	B	Wound Infection - No details					B-Pending
	C	No details listed					

Table 2.—Lawsuit Profile (continued).

Physician	Case	Alleged Injury	Defense Attorneys	Plaintiff Attorneys	Plaintiff Expert Witnesses	Defense Expert Witnesses	Result of Case
61	A	Malignant Hyper-thermia - Arrest	Johnson	Rieders Baugh	Not listed	Not listed	A-Settled $25,000
	B	Patient Fell	Martinez	Farrell	Not listed	Not listed	B-Dropped
	C	Incorrect Level - Cervical Fusion	Not listed	Not listed	Not listed	not listed	C-Settled $250,000
62 & 63	A	Vascular Injury During Diskectomy	O'Hara Leincke Korman	Schless-inger	B. Sussman Burton Wise	Aronson	A-Settled $800,000
	B	Undiagnosed Carcin-oma of Stomach	Korman	Not listed	Not listed	Not listed	B-Pending
	C	Fell from Table	Korman	Rickman	Not listed	Not listed	C-Dropped
	D	Recurrend Disc, L5-S1	Korman	Kopson	Not listed	Not listed	D-Pending
	E	Increased Deficity Following Cervical Spondylosis Surgery	O'Hara Korman	O'Brien	Not listed	Not listed	E-Pending
	F	Lumbar Disc Complication	Korman	Ford	Not estab-lished	Not estab-lished	F-Pending
	G	Intracerebral Hema-toma Following Craniotomy	O'Hara Korman	Orseck	None listed	Aronson	G-Settled $225,000
64 2 Doctors	A—I 9 suits	No details					
65	A—F	Postoperative Complications	Blackwell Walker Gray Stephens Lynn Cherdey	Rosenblatt Tanner	Levy	Johns	3 Won 3 Lost
66	A	Postop Complication, Iliac Graft	Wilson	Dewberry	None	None	A-Dismissed
	B	Complication of Injection	Smith	Rosenblatt	Unknown	Vogel	B-Pending
	C	Seizure, Post Myelogram	Collins	Lagrone	None	None	C-Dismissed
78	A—F 6 suits		Lynn Charney Creel Cabanes	Rosenblatt Brown	McMurthy Green Frankle	Lutsgarten Saiontz Cooney	3 settled $1,000,000 $ 600,000 $ 350,000 1 - Won 2 - Pending
80	A	Wrong Level Laminectomy	Levingston Brodes	Cunning-ham	Not listed	Dunne	Settled $50,000

Additional Information: Other physician numbers that have been left out of this list indicate no lawsuits - 20 of them.

myelography, pointing out the need for full informed consent in this procedure to include meningitis, contrast reaction, and seizures. It is of interest that the St. Paul Fire and Marine statistics of leading malpractice allegations countrywide for neurosurgeons included 2.6% of those claims related to myelography.[3] Several suits generated from cervical laminectomy for spondylosis, allegedly causing increased neurological deficit. One such case was based upon delay and diagnosis by a first neurosurgeon when the patient became worse following surgery by a second neurosurgeon! Four suits resulted from surgery at wrong spinal disc levels, pointing out the absolute necessity for intraoperative x-ray confirmation of surgical level. Eight suits resulted from operative infection. In one incredible case, a paraplegic patient sued one physician for not operating and sued the second surgeon for a complication of surgery.

It is tempting to draw numerous conclusions from this survey. The information obtained in this manner, however, is often incomplete and the sample is small. General trends, however, are evident. A similar national state by state survey in neurosurgery certainly would identify suit trends and who is testifying as expert witness on a regular basis. Several names appear more than once as a plaintiff expert witness from this small series of lawsuits and two names even appear three times. I have discovered also that a typed transcript of testimony or deposition is not necessarily kept in each case, particularly those which are settled. I would suggest that each of us who are sued pay for and keep a typed copy of all testimony given. An index of cases could then be developed with a questionnaire such as this one and most testimony could then be more readily accessed. At present, much of the testimony given never becomes public record. Development of accurate information about regular expert witnesses and their testimony in various trials may help to "clean up the act" in the courtroom.

The members of the Florida Neurosurgical Society who responded so promptly to this questionnaire are to be commended. Studies such as this allow us to speak from the strength of truth and facts rather than from the shaky ground of heresay and impression.

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Medical negligence and the tort system: What are the options?

Richard J. Feinstein, M.D.

On a trip to Europe this past summer, I spent a portion of the 18-hour round trip air travel rereading Charles Dickens' novel, *A Tale of Two Cities*. Most of us will remember from a high school or college literature course that the novel describes events in London and Paris just prior to the French Revolution.

The aristocracy in France under Louis XVI had become so arrogant and powerful that armed revolution became the only solution for millions of poor and downtrodden Frenchmen. Dickens describes how horse-drawn carriages transporting aristocrats rolled through small towns or cities injuring or killing people who happened to get in the way. There was no legal recourse for those maimed or killed in such a way because the perpetrators of those crimes, the wealthy aristocrats with connections to the King, also held the judicial and legal authority of the state.

It is easy to see then why modern civilized nations have laws which serve to protect individuals from the willfull or careless negligent actions of others. In most western nations, laws protect the individual whether the perpetrator is powerful or weak, an individual or the government itself. Those who willfully injure others or damage property may be subject to criminal prosecution and risk being fined or losing their freedom because of their actions. When no criminal law has been violated and carelessness has been determined to have caused damage to individuals or property, the actions fall under the purview of civil tort law. Tort or negligence law aims to punish those who are negligent by forcing them to compensate those who have been injured. Negligence laws are also intended to deter further negligence by the tort feasor and by others in society through the publication of news about the penalties meted out to those who have been found guilty.

Two factors are necessary for a finding of guilt under our present tort law: the tort feasor must have been negligent, and his negligence must have caused harm to the plaintiff. A commonly used example will serve to illustrate this point. While shopping in a supermarket with her mother, a young child knocks several jars of mayonnaise onto the floor where they break and splatter. The woman places the child in her shopping cart and proceeds to the checkout area to inform store employees of what has happened.

If another shopper walks into the area that is now slippery with splattered mayonnaise and broken glass before store employees have a chance to clean the area, then any injuries sustained by this shopper will not be the result of any negligence by the store. This second shopper may fall, sustain fractures and lacerations and may possibly even die from severe hemorrhage, yet the store and its employees should not be found guilty by a jury because no negligence has occurred.

If store employees are informed about the broken jars but neglect to have the area cordoned off and the debris cleaned as quickly as possible, then they are guilty of negligent behavior. If no other customers walk down the soiled aisle, or if they use that aisle but are careful to avoid being injured themselves, then no jury can find the store guilty because of their negligence.

If the store fails to attend to the dangerous situation quickly after learning of it, and if a customer is

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injured, then both criteria have been met to find the store guilty of negligent behavior and it may be liable for the injuries sustained by the injured customer. If the dangerous situation is allowed to continue for a lengthy period of time after the store representatives have been notified of its presence, and numerous individuals are injured in the slippery area, then the store may be guilty of willfull or even criminal negligence for not having responded properly to the dangerous situation.

We must ask at this point why any reasonable person would ever be guilty of the negligent behavior that could cause harm to other people or their property. We do know that although most people mean well, almost everyone at times is capable of behavior that is careless and injurious to others or their property. We get involved in minor car accidents. We leave tools in positions where others may sustain an injury. We throw baseballs and footballs that break windows and strike passersby.

Certain occupations and activities are more prone to harm property or other people. Police in the pursuit of suspects may damage property, and they may injure or even kill innocent people. Professional or amateur boxers or football players may injure or kill others. Manufacturers of automobiles, tires, airplanes, electrical equipment and other items may possibly injure individuals who use the products they produce.

An automobile manufacturer's product may have a defect which can ultimately harm the driver, passengers or pedestrians because of defects in function. The defect may be unknown to the manufacturer because of undetected flaws in the design or manufacturing process, and if people or property are injured through this negligence, a jury may find the manufacturer guilty and order him to pay for any damages that may have occurred.

We have all read accounts by engineers from major manufacturing companies who claim that company managers knew of design flaws in automobiles, tires, space shuttle boosters or other products, yet made the decision to manufacture and sell those products to consumers anyway. If the design flaw was responsible for injuries to consumers, then it would seem reasonable for a jury to not only find the company negligent and responsible for those injuries and damages, but also to decide that criminal negligence had occurred and order additional monetary punitive action against the company or against the managers individually. Managers could also be jailed for criminal negligence.

It is possible to understand why an assistant vice president or a division chief of a large manufacturing company would allow a product with a possibly dangerous design flaw to be produced and sold anyway. These, after all, are businessmen whose interest lies in the bottom line, and if they learn about a design flaw too late when a change could prove too costly and embarrassing for them and their company, they may tend to make the product anyway. In addition, aside from the tremendous financial pressures, these men and women are both physically and emotionally removed from the consumers of their products. They most likely will never meet someone who has been injured because of their negligence.

Why would a physician ever perform negligently? Physicians don't produce products that are sold to anonymous consumers. We don't sit in board rooms or at check-out counters and make intentional decisions that affect individuals who we may never see. We also learn very early in our lives and most certainly very early in our medical careers the value of trying to do things the right way.

A surgeon who is well prepared and well trained, who selects his case properly, generally obtains good results and is a content and happy person. The years of medical education and medical and surgical training; the continuing education and the honing of surgical skills; the interest in maintaining his or her own mental and physical health all meld to make it very likely that the surgical case will go well. A cholecystectomy, coronary bypass or craniotomy will be performed rapidly, skillfully and often even joyfully. If the patient has been selected well and prepared psychologically for the most likely outcome of the procedure, he or she will be content with the results as well. The surgical fee will most likely be quite good compensation for the time and effort expended on the case, and the patient will tell others who may need surgical treatment as well. The surgeon's practice will thrive, and he or she will achieve professional and economic success.

Compare this to the surgical case that goes awry. A scheduled two hour surgical case may wind up lasting six or eight hours. The patient may bleed unexpectedly when a major vessel or organ is inadvertently injured. There may be postoperative bleeding, wound dehiscense or infection, and the patient may have to be taken back to surgery. The patient may have to spend days or weeks in an intensive care unit, requiring constant attention, multiple daily visits, and endless concern. The well-compensated two hour surgical procedure will have turned into a hundred hours of misery for the surgeon, reducing hourly income to a figure perhaps below the minimum wage of $3.35 an hour.

But the ten, hundred or even the thousand additional hours of work and concern pale in magnitude when compared to the long hours and emotional energy that will be needed to deal with the inevitable malpractice claim. The postoperative bleed, the damaged organ or the ligated ureter which took only seconds of inadvertent behavior to create, will produce a nightmare for the physician that will seem interminable and unending. The humiliating depositions, documents for review, meetings with counsel and claims committee, and trial dates and altered trial dates will all seem to go on forever.

The patient, once a beloved client, will have turned into a hating and angry adversary. You may no longer see him or his family as patients, but you will see his medical records, photographs, reports from the plaintiff and defense attorney's consultants, and perhaps his or her autopsy report, without letup. A small but definite group of your existing and potential future patients will seek treatment from other physicians because of knowledge and publicity about this case.

Anxiety will remain even longer after the case has been settled or decided by a jury. The memory of the case will affect every future patient you treat and perform surgery on for a very long time and possibly for the rest of your life. This memory may create indecision at critical times in the care of other patients which may cause you to make errors in judgment and further mishaps. You may view all patients as potential adversaries, making you hostile and paranoid.

Physicians are bright people with good instincts for self-preservation, so why would they become involved in any endeavor that is likely to go wrong and produce so much unhappiness and anxiety for such a long period of time?

Knowing the devastating and long-lasting effects of any careless act, why are physicians ever negligent? Physicians are bright people with good instincts for self-preservation, so why would they become involved in any endeavor that is likely to go wrong and produce so much unhappiness and anxiety for such a long period of time?

The answer to this question is complex because physicians as a group of individuals are complex and heterogenous. There are some physicians who are incompetent and should not be practicing medicine. All medical school deans know of graduates who should have been kept behind. There is a very small percentage of physicians who are sociopaths or who suffer from other forms of mental illness and, like the businessmen at the automobile company, they may not understand when they are injuring patients because they are concerned about other factors. They are unable to see that their success as physicians lies only in their patients' well being. These physicians may be brilliant and have impeccable credentials, but they lack the judgment and sensitivity that physicians must possess to consistently perform well over a long period of time. Medical disciplinary boards must deal more effectively with physicians who demonstrate a protracted behavior of incompetence and unconcern for patients.

Some physicians were once competent, but drugs, alcohol, mental illness, senility, physical debility, or other factors have interfered with their ability to perform competently. The deterioration of clinical skills and judgment may be gradual and difficult to detect at first, but certainly the disability often reaches a level before patients are harmed when other physicians, nurses and family members are aware of problems. By failing to intervene, all physicians are contributing to the malpractice crisis. By failing to refer and coerce impaired physicians into well known and publicized treatment programs and away from patient care, we are all harming the patients of these doctors and sharing their burden as tort feasors.

The entire medical profession is paying and will continue to pay to compensate those who are injured by physicians who should have been identified by colleagues and removed as incompetent. Any proposals toward legislative solutions to the malpractice problem must include the commitment by individual physicians and their organizations to cooperate with the state medical board's desire to remove incompetent physicians from the practice of medicine.

In reality, relatively few practicing physicians are impaired or suffer from sociopathic personality disorders or chronic problems in making sound medical judgmental decisions. Most physicians are intelligent, well trained and competent men and women who seek only to perform well and help their patients. But physicians are humans and as such we will all at one time or another make errors or perform at a level of competence that may be less than satisfactory. If a physician injures a patient because of negligence, then that patient should be compensated in a reasonable way for those injuries. Compensation should include payment of medical expenses incurred, lost wages; and some reasonable amount for discomfort and suffering.

Physicians who injure patients through honest mistakes should not be treated like criminals by the court or plaintiff attorneys. The judicial system should be altered so tort feasors may pay reasonable damages to compensate those who are injured through negligence without having to be humiliated before a jury and the public.

Physicians should not have to pay punitive damages when a patient has been injured through negligence when the doctor has acted in good faith as an honest and decent medical practitioner. If the plaintiff or his attorney suspect willful or criminal negligence, the case should be referred to criminal court for possible indictment and then later referred for civil action for determination of civil guilt or innocence and the determination of damages.

Physicians should be held only to a level of care offered by the average and not the best physician performing the same medical procedure. Most physicians, as most people, are average and it is unfair to expect the average practicing physician to meet standards set by academic doctors who may possess special or even unique qualifications in certain medical or surgical areas. Academic doctors may practice in unique

settings with special colleagues, such as anesthesiologists, who may be unique themselves and these individuals may not understand how medicine is practiced at community hospitals and in private medical practices.

Any proposals toward legislative solutions to the malpractice problem must include the commitment by individual physicians and their organizations to cooperate with the state medical board's desire to remove incompetent physicians from the practice of medicine.

Expert witnesses must also be practicing doctors who understand the clinical setting, procedure, and stresses incurred by the defendant charged with medical malpractice. It is absurd that in 1987 courts in Florida would still allow retired general surgeons or family practitioners from California or New York to serve as experts in neurosurgical or obstetrical cases.

Judges must maintain greater input into the judicial process in a fair and honest manner. If a judge observes that a jury has not understood the case or has become angry at the physician defendant for some irrelevant matter, such as his or her demeanor or style of dress, then the judge must instruct the jury about their obligations under the law. A jury must not be allowed to order punitive damages unless the physician has actually demonstrated wanton or willfull negligence, and perhaps a criminal indictment should be sought on those rare occasions.

Physicians and their insurance companies should attempt to settle cases and make reasonable reparations for injuries sustained through negligence. Physicians who have been determined by their insurance company's claims committee to have been negligent should attempt to use the process as an educational experience. Those who do not should be dropped by the insurance company, not because of the claim but because physicians who are incapable of understanding their contributions to a patient's injuries are very likely to injure future patients through negligence. The Legislature should consider requiring malpractice insurance companies to report to DPR and the Board of Medicine, as hospitals and medical societies must now do, all physicians who have been dropped as insureds.

Judges and juries must pay special concern to the milieu in which the patient is alleged to have sustained injuries. They must temper all their deliberations so that physicians and nurses, who work in emergency situations on critically injured or ill patients, are given all possible benefits of the doubt. Few humans aside from those who work as health care professionals have any comprehension at all about the utter anxiety and desperation that is involved in administering to critically injured people who are near death before the first health care worker has begun his or her efforts. Only other emergency health care physicians and nurses, who work in similar hospitals under similar conditions, should be allowed to testify as experts, for only they understand what it is like to care for these desperately ill people.

There are other suggestions as well. All malpractice awards should be structured. Attorneys' fees can be paid up front but the level of contingency fees should be reduced. If the person injured through negligence does die, all remaining proceeds from the award should revert back to the insurance company or some other fund. Family members of the plaintiff should not benefit from the injury by becoming millionaires at society's expense. Tort law has evolved to compensate victims of negligence, and not to serve as a lottery for family members and other beneficiaries.

● Dr. Feinstein, 3661 South Miami Avenue, Miami 33133.

PL 94-142 and PL 99-457: Challenges for pediatrics

William S. Downey Jr., M.D.

INTRODUCTION: PL 94-142, the Education for the Handicapped Act, was enacted ten years ago providing a free and appropriate public education for every handicapped child from five to 21 years of age regardless of the nature or severity of the handicap with states having the option to include children from the age of three years. In 1986 a new law, PL 99-457, amended the previous legislation and further extended the optional component from birth to previously stated ages and made the previous discretionary three to five year old provisions mandatory by the year 1992. The provisions of each of these statutes are highlighted and the ramifications of each are discussed along with the implications for pediatricians and family practitioners. The amendment will surely bring about the collaboration of pediatricians and public school educators in their joint planning for infants and toddlers and will underscore a greater need for developmentally oriented, medical examinations for infants by physicians.

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Ten years ago a new arrival was presented to the American family or society. It caused some of the family to rejoice while other reactions were either more reserved or negative. The newest member was PL 94-142. The family is now celebrating the tenth birthday of PL 94-142 and is anticipating further growth in its teenage years.

The American family is further enhanced by yet another new arrival this year. While a sibling of PL 94-142, it is not a clone. Although technically an amendment to the original law, it is vital in its own right, with a direction and provision uniquely its own. It is PL 99-457 and presents new challenges and demands to its American family, especially to those members who are medical practitioners.

PL 94-142 ● In 1975 the 94th Congress noted that there were more than 8 million handicapped children in the U.S., that the special education needs of these children were not being met and that more than half of all handicapped children did not receive appropriate educational services which would enable them to have full equality of opportunity. Accordingly legislation was enacted "to assure that all handicapped children have available to them a free appropriate public education which emphasizes special education and related services designed to meet their unique needs."

This act required all states to provide these services from ages five to 21 but allowed the states to individually consider extending these services to preschool children age three and above as well, unless in conflict with existing state laws. Florida had a law providing education until 18 years of age with education programs permitted until 21 years of age in certain categories.

One important provision of PL 94-142 required

that each child to be served have an Individual Educational Plan (IEP). The IEP would be developed by a team to include the teacher, parents, and other personnel with special expertise. Many states mandated that each child was to have a medical examination with report but this was not required in Florida. The physician was not a mandated member of the IEP team although it was possible to include him since his expertise could contribute to a more effective educational plan.

Other provisions of this act directed that the child must be educated in the least restrictive environment, i.e., not separated from his nonhandicapped peers, unless such separation was essential for the optimal outcome of his educational plan; that each individual education plan be reevaluated yearly; that disputes between parents and school authorities concerning the optimal educational plan for the child be resolved first by independent arbitration and, if unsuccessful, by recourse in the courts; that the state education agencies develop plans for producing trained persons to fulfill these new roles in education; and that each state have an advisory board for special education.

In November 1986, Madeleine Will, Assistant Secretary for the Federal Office of Special Education, prepared a report entitled "Educating Students with Learning Problems - A Shared Responsibility." This was an analysis of the successes and problems of PL 94-142. In 1985, in the United States, 1.8 million children in our nation's public schools were classified as "learning disabled", about 4% of the 42 million total. Another 10-20% were receiving some kind of special education because of some physical, sensory, learning, language or behavior problems that impeded their educational progress.

The quality of the educational assessments and remediation have steadily improved. Special educators have gained experience in the past decade.

However, there still are problems. Quality programs for assessment and evaluation of individual students are now available in most urban and many rural areas, but four areas indicate further efforts are necessary. First, the high school dropout rate is still very high and many of those who drop out have long histories of learning problems. Second, there continues to be delays in enrolling students in remedial education. Third, there is a nonflexible definition of eligibility for remedial programs even when the need is clearly identified when "testing" scores indicate otherwise. Finally, a student found to be learning disabled during his IEP assessment may be placed in an inappropriate program but more cost-effective for the school system. These are just a few of the more major problems a student may have in accessing the system and there are minor barriers as well. Some parents are loathe to allow their children to get special help because of the stigma attached to it. Some students are taken from the regular classroom to spend a period in a resource room to get some special help only to suffer from the loss of what the class was being taught in the regular classroom.

Another problem is that far too many children fail to get remediation early in their academic careers. Only when it is painfully obvious to both teacher and student that something is wrong and that it is not going to go away without help are remediation efforts finally begun. By this time the child has experienced frustration, defeat and a painful loss of self-esteem, that will diminish the effectiveness of the remedial program when it is started.

During 1986 in Florida, of the 1.6 million students enrolled in the public school system, about 237,000 received some sort of special education. The state employs over 10,000 teachers in special education. During this 1986/1987 school year, the total cost of special education programs from K-12 is approximately $550 million of the total school budget of $4 billion.

PL 99-457 ● President Reagan signed into law the Education of the Handicapped Amendments of 1986, PL 99-457, on October 8, 1986. There are three main sections of this bill: Title I: Handicapped Infants and Toddlers; Title II: Handicapped Children Aged 3 to 5; and Title III: Discretionary Programs.

The first two titles involving infants, toddlers and preschoolers will require the greatest involvement of pediatricians since no one else has the expertise of all aspects of these aged children, medical, cognitive and developmental. Title III is involved in renewing research and development grants for the education of the handicapped.

Title I begins with these thoughts: "The Congress finds that there is an urgent and substantial need (1) to enhance the development of handicapped infants and toddlers and to minimize their potential for developmental delay, (2) to reduce the educational costs to our society, including our Nation's schools, by minimizing the need for special education and related services after handicapped infants and toddlers reach school age, (3) to minimize the likelihood of institutionalization of handicapped individuals and maximize the potential for their independent living in society, and (4) to enhance the capacity of families to meet the special needs of their infants and toddlers with handicaps."

The salient provisions of Title I are many. The target population of PL 94-142 is extended from ages 3-21 down to birth. Individual state participation in the provision of Title I is distressing in that each state may or may not participate but there are very strong incentives to encourage joining this new adventure. For the first time federal funding is made available to establish a system for early intervention services to disabled children from birth. Fifty million dollars was appropriated for FY 87 and $65 million for FY 88 to be used by the states to plan and implement this section.

States which choose to participate must meet certain provisions in their educational structure and services. The statute calls for "a statewide system of coordinated, comprehensive, multi-disciplinary, interagency programs" including a child find component, central directory of all available services and experts in the state, public awareness program, comprehensive system of personnel development and a single line of responsibility in a lead agency designed by the governor.

It calls for each handicapped infant to get an Individualized Family Service Plan (IFSP). This IFSP has many things in common with the IEP of PL 94-142: the parent must be involved, the plan must be timely, it must include a multi-disciplinary assessment of the needs and the identification of services, and it must be reviewed at least yearly. Where it differs is that the IFSP requires a statement of the infant's present levels of physical development, cognitive development, language and speech development, and psychosocial development, as well as a statement of the family's strengths and needs relating to enhancing the development of the family's handicapped infant or toddler.

One important provision of PL 99-457 is to mandate that each state choosing to participate establish a State Interagency Coordinating Council composed of 15 members. There must be at least three parents of handicapped infants, toddlers or preschoolers, at least three public or private providers of early intervention services, at least one representative from the state legislature, at least one person involved in personnel preparation, and other members representing each of the appropriate agencies involved in the provision of early intervention services. The council is required to meet quarterly, preferably at open meetings, and "shall advise and assist the lead agency."

The responsibilities of the lead agency is the general administration of the programs and activities, identification and coordination of all available resources, assignment of financial responsibility, development of procedures to ensure that services are provided to handicapped infants and toddlers in a timely manner, resolution of intra and interagency disputes and the entry into formal interagency agreements.

The intervention services are to be provided at no cost to the family by qualified personnel including special educators, speech and language pathologists and audiologists, occupational therapists, physical therapists, social workers, nurses and nutritionists. Special intervention services may also include family training, counselling and home visits, speech pathology, occupational and physical therapy, while medical services are enlisted only for diagnostic or evaluation purposes and health services only as necessary to enable the infant or toddler to benefit from the other early intervention services.

Title II is significant in that it replaces the current, discretionary, preschool incentive grant program and mandates that by 1992 every state will provide free and appropriate public education and related services to disabled children from age three. It further significantly increases the level of funding for the programs that currently exist.

Florida statutes and services ● In 1986 the Florida legislature passed the Handicapped Prevention Act of 1986 (Chapter 411). This statute has specific parameters for the definition of "handicapped child" and "high risk child". It establishes a continuum of integrated services to identify, diagnose and treat high risk conditions in pregnancy and in young children between the ages of 0 to five years. It further requires a report, jointly prepared by the Department of Health and Rehabilitative Services and the Department of Education, to be presented in March 1987 to the state legislature, to include such items as identification of services currently available, proposed changes and recommendations for legislative, administrative and budgetary changes.

Also in 1986, the Florida legislature, in Chapter 86-261, established the Prekindergarten Early Intervention Program for children who are three and four years of age. The school districts are encouraged to submit proposals for programs which "might serve as preventive measures for children at risk of educational failure and to enhance the educational readiness of all children." It is administered by the Early Childhood and Elementary Education Division of Public Schools and has its own State Advisory Council on Early Childhood Education with a pediatrician as a member, William Ausbon, M.D., Director of Children's Medical Services, HRS.

There are many remediative preschool programs in Florida but not every eligible child is receiving services. In FY 85-86, for ages three and four, the estimated number of handicapped children was over 10,000 with about one fourth receiving help. In the ages 0 to two, 3,700 were estimated to be eligible with only 200 getting help. Currently the cost of all the prekindergarten programs is about $950,000 and this law will immediately increase that funding to about $6,000,000.

Gov. Bob Graham, before leaving office, established the State Interagency Coordinating Council and appointed the required 15 members. Fortunately two of the members of the council are pediatricians. They are Robert Stempfel, M.D., of the University of Miami, chairman, and James White, M.D., of Ormond Beach. The governor named the Department of Education as the lead agency for Florida. This makes it easier to coordinate efforts of PL 94-142 programs and efforts with those of the new PL 99-457. These actions enable Florida's children to immediately be able to benefit from this law, to initiate an application for federal funding and to begin the planning process.

Discussion of the pediatric roles ● PL 99-457 is more than simply an extension of PL 94-142. The handicapped newborn is considerably more likely to have major medical problems than the educationally handicapped eight-year-old child. This fact will make the pediatrician a more prominent source of referrals and consultation than in the past. Although PL 99-457 is an act under the direction of the Secretary of Education in Washington, many states have chosen for the "lead agency" mandated under this law the State Health Department, not the State Department of Education, because the medical component looms much larger. This underlines the fact that the implications for PL 99-457 are "medical", perhaps even more so than "educational". However, the benefit of naming the Department of Education as the lead agency in Florida has its advantages in that it coordinates the two laws most readily.

The Individualized Family Service Plan calls for "the name of the case manager from the profession most immediately relevant to the infant's and toddler's or family's needs who will be responsible for the implementation of the plan and coordination with other agencies and persons." This managerial role is one that pediatricians have been fulfilling for decades. It is reasonable to assume that their expertise will have a major influence in the evolution of PL 99-457 IFSPs, more so than with PL 94-142 IEPs, because the former are more likely to involve medically oriented problems including infant development. These are two areas where educators are not trained or experienced.

In 1975, when PL 94-142 came into being, how many educators had expertise in the problems of children starting at age three? Initially there was an appalling lack of trained special educators and few tried and true programs. Now the programs are considerably better, the educators are specially trained and the quality of services thusly improved. In 1987, how many educational settings have expertise with infants and toddlers? There are many disciplines which have worked with this age group but the pediatricians have the most encompassing experience, understanding the growth and development of children, with wide ranges of normalcy, influenced by a wide variety of family dynamics, all of which are part and parcel of everyday pediatric or family practice.

The specialty of pediatrics has, as one of its hallmarks, the stressing of prevention and early intervention. The prologue to PL 99-457 concurs with that philosophy and should be received with excitement. However, pediatricians have a responsibility to extend this to the areas of PL 94-142. There are too many children who are having learning problems, who have their first Individual Educational Plan in the third to sixth grade when their teachers have been complaining of their academic deficiencies from as early as kindergarten. What is needed is for the children to be identified in kindergarten or first grade, or even in day care at the ages of two or three. A liaison should develop between these early caretakers and teachers with pediatricians to introduce needy children to the benefits of these statutes earlier. Hopefully this liaison will follow naturally as the interdisciplinary team experience develops over children with more severe handicaps.

These two laws have stressed interdisciplinary tactics. PL 99-457 will require more disciplines to be involved than PL 94-142 has required. The pediatrician will need to establish the lead in providing the climate that ensures interdisciplinary, rather than multidisciplinary, actions. The distinction between interdisciplinary and multidisciplinary is that in the latter term several disciplines see a child separately, write a report with their insights and recommendations, and someone tries to assimilate them into a common plan. In interdisciplinary actions, the various disciplines evaluate the child and then interact together, sharing insights and establishing an appropriate plan. The pediatrician's previous experiences in marshalling the resources of the community for a patient will enable him to be effective in this regard. Project Bridge, a joint effort of the American Academy of Pediatrics and the Federal Department of Education is an excellent first step to develop techniques in this regard. On March 6, 1986, Project Bridge sponsored a videoconference simultaneously in several cities throughout the country about the interdisciplinary process. Currently the project has regional educational centers to promote the concept. The center for the region containing Florida is at the University of Alabama at Birmingham, Fred. J. Biasini, Ph.D., Director, (205) 934-2452. Every physician, who has not taken advantage of its offerings, should pursue learning more from this excellent resource.

Another aspect of the pediatrician's role is that of advocate for the child. The child's doctor is in a unique position to understand the child's assets and deficiencies, and his family's abilities to address his needs. He is a leader of the community. The pediatrician's efforts on behalf of the child are independent of the school district since he is not an employee of the local school district. PL 99-457 underscores the advocacy role of the pediatrician for the infant, toddler and preschool child, assuring a richness of intervention for the child at a time when beneficial effects are most likely.

The Florida Pediatric Society and the American Academy of Pediatrics must play a decisive role in implementation of this legislation. There is a pediatrician on the state advisory committee for PL 94-142 and two pediatricians on the Interagency Council for PL 99-457. These are the two policy making groups. At least the first two years for the infants and toddlers section are years for "planning." Initially the most significant item to be decided is the question of what constitutes developmental delay. The law leaves it up

to each state to define it. However, it also reads that it "may also include, at a State's discretion, individuals from birth to age 2 inclusive, who are at risk of having substantial developmental delays if early intervention services are not provided." If this is adopted, would infants of 15-year-old mothers be eligible? Or infants of mothers with a fifth grade education? Or infant siblings of severe school underachievers? Or infants of child abuse?

The members of the American Academy of Pediatrics who worked on the drafting of this law were disturbed by the words, "medical services only for diagnostic or evaluation purposes." The Academy has promised to work to clarify this point in the law.

PL 94-142 has played a signficant role in the cognitive growth and development of our school-aged children for the past ten years. Its future is one of promise and continued progress. PL 99-457 is equally important because it calls for early intervention for handicapped infants and toddlers. Pediatricians should find in them new arenas for their professional expertise.

● Dr. Downey, University of Florida College of Medicine, Department of Pediatrics, Box J-296, Gainesville 32610.

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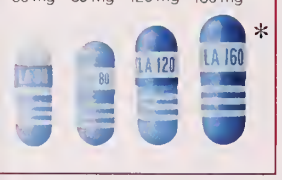
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

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WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia; congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations, vivid dreams, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

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1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.

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The terminal agony and final moments of a physician-owned HMO: A postmortem

"Wisdom rises upon the ruins of folly."
Thomas Fuller, M.D. 1732

Many physicians in Florida have enrolled as health care providers in Health Maintenance Organizations (HMOs). Most HMOs in the state are Individual Practice Associations (IPAs) in which the physician agrees to provide care in his office and hospital for a captitated or contracted fee schedule. Frequently the IPA is owned by the physician-providers, i.e., the physicians purchase stock, assume risk for the losses, and contract out the marketing and administrative maintenance to insurance companies or similar organizations.

IPAs in the United States comprise the vast majority of the new HMOs that have been established during the past three years. Most of these HMOs are currently losing money. It has been estimated that many of them will financially fail in the next one to two years. Florida has 35 IPAs. Statistically, many of them should be feeling the financial stresses that other IPAs in the United States are experiencing. The Florida Department of Insurance did not wish to reveal the degree of distress being felt by state HMOs. To date, only three of the Florida HMOs are in receivership; Sunshine Health Plan, which had existed in Volusia, Brevard and Flagler Counties until recently, is one such financial catastrophe. Hopefully, a postmortem examination of the causes of Sunshine's terminal economic illness and demise will guide other HMO physician participants and enable them to parry the financial losses incurred by the Sunshine health care providers.

Sunshine Health Plan was started in 1979 by a group of Volusia County physicians and became operational in October 1980. A staff model HMO had been established in Daytona Beach previously and a need was felt by the doctors to offer the community a competing HMO that would maintain the high quality of traditional, fee-for-service medicine. Patient recruitment, screening, and administrative duties were conducted by an insurance firm based in Daytona Beach.

Sunshine was profitable through 1985; it achieved peak profits in 1984 of almost $155,000. Its profits shriveled to $12,000 in 1985 and in 1986 it experienced a huge loss of $1,353,000. But the fiscal hemorrhage in 1986 accelerated into 1987. For the first seven months of the year it compiled additional losses totalling $1,853,000.

In the middle of July, the Florida Department of Insurance advised the plan to either raise an extra $3,000,000 in capital or be forced into receivership. Receivership would force the plan administrators to surrender operations to state personnel. The obvious question is "How could a plan, that was successful for its first five years of existence, experience such a sudden reversal from profitability to bankruptcy in the short span of one year?" Many reasons exist: an overaggressive enrollment campaign for new members, a lack of cost control data about its physician providers, an excessive rate of hospital utilization in comparison to other HMOs, flawed actuarial advice, and the need to underprice its services to remain competitive.

The major reason for the plan's demise is probably the decision in 1985 to aggressively increase enrollment. At the end of 1984 the plan had 3500 members; the enrollment was 6400 at the end of 1985 (a 78% increase) and 11,500 by the end of 1986 (another 80% increase). By the middle of 1987 it had over 13,000 enrollees. In 1984-85 Humana Care-Plus and Gulf Life Insurance Company aggressively recruited local business concerns in Volusia and Brevard Counties with their PPO and indemnity health insurance plans. A threat of potential loss of members for the Sunshine Health Plan was perceived. Since HMOs with memberships smaller than

20,000 members suffer a relatively large overhead/total cost ratio it was felt that the plan needed to expand in order to survive. The advertising budget was increased. Care in the selection of patient members was deemphasized whereas prior to the recruitment drive, high risk employee groups and individuals had been screened and denied coverage.

"How could a plan, that was successful for its first five years of existence, experience such a sudden reversal from profitability to bankruptcy in the short span of one year?" Many reasons exist: an overaggressive enrollment campaign for new members, a lack of cost control data about its physician providers, an excessive rate of hospital utilization in comparison to other HMOs, flawed actuarial advice, and the need to underprice its services to remain competitive.

Rapid expansion of a health plan membership accelerates costs for several reasons: There is an administrative cost associated with enrollment; marketing expenses necessary to attract new members can be large; an initial physical examination is required for most new members and this increases outpatient costs; and new plan participants will not be as willing as other members to limit utilization of the health care offered.[1] Additionally Sunshine offered a generous bundle of benefits, including a munificent prescription plan, with a minimum copayment. These features made the plan very attractive to people with less than optimal health status.

The second egregious reason for the failure of the plan was the nearly total lack of quality control or cost containment efforts. The designers of the plan desired to allow the doctors to practice medicine "as usual." Until late 1986 no information was available as to the practice patterns and costs of the individual physician providers. HMOs that succeed do so by means of rigorous data review, physician education, and, in some cases, disciplinary actions against high cost providers. There was a 10% "holdback" from the usual, customary fee that physicians were paid (this was increased to 20% at the end of 1986). This holdback, like most such holdbacks, does not effect cost containment for HMOs. Rather it encourages some physician to overutilize other services so that they can redeem the discount that was granted to the HMO.

The medical care costs per member per month varied enormously among the physicians listed as primary care doctors (defined as family practitioners, general practitioners, internists, OB-GYNs, and pediatricians). For those doctors who were primary physicians for ten or more patients the health care costs varied from $19.35 to $227.37 per member per month. For those doctors with over 100 patients in the plan, the range varied from $14.97 to $118.13 per member per month. The median was $59 per member per month for all doctors. Thus, there was a 790% differential in the cost per member per month among the physicians seeing in excess of 100 plan members per year. No differences in utilization were observed among the five types of primary care physician, i.e., utilization among internists ranged as widely as did utilization among OB-GYN or pediatric specialists. This does NOT imply that all high cost physicians were wasteful in their use of medical services; these data are raw and do not correct for the severity of patient illness, or for the distortion of the figures that arise from the clustering of a few very sick patients within one physician's practice, etc. The difficulty is that the data simply do not exist to even examine the reasons for the high differential in costs among plan providers. Age-adjusted utilization rates by enrollees were not examined. Cost comparisons for the services provided by individual subspecialists were not available. The only conclusion that can be made from the available information is that doctors who are highly regarded as "excellent" practitioners in the community do not necessarily practice expensive medicine. The majority of the physicians who are highly respected by other doctors for their patient care and knowledge provided medical care at a cost at or below the median cost of the entire physician-provider group.

A third cause of Sunshine's failure was the high utilization of hospitalization. Sunshine Health Plan did not enroll elderly, Medicare eligible patients; yet its hospitalization rate was 525 days/1000 members. In comparison, federally qualified, other Florida IPAs experienced an average hospitalization utilization rate of 393 days/1000 enrollees. If one assumes the cost of a hospital stay at $659 per day, then the difference in the hospitalization rate between Sunshine and other Florida IPA HMOs accounts for over $950,000 of their 1986 loss. Obviously, not all of this loss would have been saved if the excess number of patients had been managed in an ambulatory environment. Perhaps 75% of the $950,000 would have been preserved. Additionally there was a large difference in rates of hospitalization between Volusia County enrollees (463 days/1000 members) and Brevard County (628 days/1000 members). An exploration of the reasons for this wide disparity has not been addressed.

A fourth problem was the imprecision in the actuarial estimates of health claims incurred but not yet reported (IBNR), which inflicted another fatal wound. This figure is important; it provides the plan administrators the information upon which to price the plan contracts for the ensuing year. The actuarial estimates for the IBNR for 1985 varied from $463,000 to $565,000. The actual IBNR exceeded $1,000,000 - a 100% error. Whether this error was due to faulty actuarial analysis or due to inadequate data provided to

the actuaries is unknown. The error led the plan administrators to underestimate the 1987 cost per member per month at $71.39. The actual per member per month cost was $84.85 - or a net loss of over $13 per member per month. Eliminating payment of the risk reserve holdback to doctors would conserve $4.16 per member per month. Even with the use of such crafty accounting devices, the plan was losing $121,000 per month by July, 1987 because of its underestimates of true costs.

The fifth reason for Sunshine's fatal illness is the excessive enrollment and underestimation of premium costs of health care provider enrollees. Employees of physicians and hospitals used more health care than other members of the communities. Sunshine enlisted 51 health care provider groups, including members of the staffs of three hospitals. Claims by members of the hospital groups exceeded premiums by 30 to 105%. Claims by the entire group of medical providers exceeded premium income by 38%. The medical care provider group accounted for 31% of the entire claims experienced for 1987 but paid in only 23% of the total premiums.

The consequences for the physicians who acted as health care providers for the Sunshine Health Plan have been rather severe. All physicians lost their initial stock investment which varied from about $500 to $1285 per doctor. A more painful result has been the loss of the payments for rendered services. Most of the primary care physicians who took care of the majority of patients have lost $10,000-$15,000 to date. One physician is owed over $30,000. However the losses have not ended but are ongoing. All doctors are contractually obligated to continue care for at least two months after they discontinue their plan affiliation. Most physicians have continued to provide care, even though they have been unreimbursed for the past several months. Total losses by physicians to date exceed $1,700,000. Hospital providers are owed an additional $2,400,000. The chances of recovery of any of these losses is slim. It is estimated that less than 30% of the owed monies will ever be paid to the providers.

This dissection of the corpse of Sunshine makes it appear that those of us who participated in the plan were dancing in a cotillion for buffoons. This is not the case. The irony is that this course of events was typical of rapidly expanding HMOs. A report on HMO financial feasibility[2] has estimated that the typical HMO similar in size and developmental stage to Sunshine would lose approximately $9.50 per member per month (comparable to Sunshine's loss of $8.80 per member per month) and would experience an administrative overhead rate of about 25% compared to Sunshine's 15% overhead. As HMOs become larger and older these overhead rates drop to a range between five and ten percent. It takes about three years for an HMO to financially ripen and return a profit. Twenty percent of HMOs are money losers even after ten years of existence. This prolonged waiting period for profitability necessitates the availability of capital to offset the losses and maintain the plan's financial viability. Sunshine was oppressively undercapitalized. The physicians had contributed $305,700 and the managing insurance company $450,000. The amount of capital required to survive the current ebb tide of funds exceeds $3,000,000. The unavailability of such a sum has tumbled the plan.

Only fools fail to learn from the anguish of others. What lessons can we derive from the travails of Sunshine?

First, the financial failure of Sunshine does not herald the wholesale failure of other HMOs. The HMO movement will be sustained by the government and the insurance industry. Over 1,000,000 Floridians currently receive medical care from an HMO. Nationwide estimates indicate that 30,000,000 to 70,000,000 people in the U.S. will be enrolled in HMOs by 1990. Most of us loathe the necessity to enlist in an HMO to protect our patient base and our income. Most of us are highly individualistic (after all, we were selected by medical school admissions committees because of our independence of personality) and we adapt begrudgingly to the practice contraints imposed by the HMO system. However, HMOs are one of the melancholy realities of physician existence so we must endure their presence.

Secondly, if doctors are to assume financial risk for the fiscal peccadillos of the HMO then doctors must become involved in the daily management of the HMO, particularly in the arena of cost containment and quality control. Quality control cannot be effected at a monthly, two hour meeting; it must be ongoing on a daily basis. The Sunshine experiment clearly demonstrated that cost containment review by a committee of bewildered physician acolytes is futile.

A well remunerated, full-time physician who understands the local medical culture is mandatory for an IPA. Sunshine certainly would have benefitted by paying a physician an $100,000 annual salary to provide ongoing review. Such a reviewer does not have to perform in the fashion of the punitive, geographically and intellectually removed physicians who populate the PROs. Rather such a person can review charts and charges of patients whose claims exceed the statistical expectations of the budget, interview the doctors to determine the extenuating circumstances about the high cost of certain cases, and educate the doctors who continually overutilize. Such a physician could be employed to develop a group camaraderie among the IPA participants and dispel the hostility that so frequently prevails between HMO administration and physician providers.

Caulking the cracks in the fiscal system in a timely fashion will prevent the perpetuation of mischief that was experienced by Sunshine. Failure to recognize the critical nature of its finances at an early stage contributed to its extinction. Sophisticated computerized controls that are designed to update the

potential claims and identify problems at an early stage is certainly mandatory but was not available to Sunshine. The fact that its 1986 unfiled claims were underestimated by 100% was due to the lack of such a system. The requirement for administration notification of all hospitalizations and high cost procedures within a narrow time frame would have prevented this and could have negated the underestimation of premium costs for the current year.

It behooves doctors to dig into the finances of their own IPAs. Their failures are costly to each of us. More importantly, the financial failure of HMOs deprives the patients of continuity of care and often terminates their insurability. A new insurance carrier may deny patients coverage for a chronic disease for periods that extend up to two years after enrollment. This can be economically catastrophic for some people. Physician-owned IPAs that fail cloak the physician providers under an odious shroud. Other Florida IPAs will fail during the next year or so; hopefully the lessons related in this article can prevent some of the potential calamities that occurred here.

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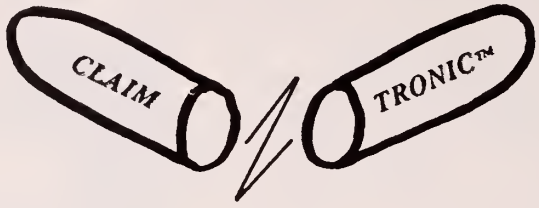
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DEPARTMENTS

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NOTES & NEWS

Joint Commission adopts new name

The Joint Commission on Accreditation of Hospitals, which has served as the nation's principal healthcare standard-setter since its establishment in 1951, announced that it is changing its name. At its meeting on August 29, The Board of Commissioners voted unanimously to endorse a name change to Joint Commission on Accreditation of Healthcare Organizations. The change is effective immediately.

Commenting on the change, Charles A. McCallum, D.M.D., M.D., chairman of the Joint Commission Board, noted that "Over the past two decades, the Joint Commission has progressively developed standards applicable to a broad spectrum of organized healthcare settings. Today, the five accreditation programs evaluate long term care facilities, ambulatory care organizations, various mental health facilities and programs, and hospices, in addition to hospitals."

In 1988, the Joint Commission will initiate a new home care accreditation program, and developmental efforts are underway to explore effective methods for reviewing HMOs and IPAs. "As this evolution of evaluation capabilities continues, we believe that it is important that the Joint Commission's name accurately reflects the organization's scope of activities," stated Dr. McCallum.

"Even hospitals today are often more complex than the traditional acute care facilities we have known," explained Joint Commission President Dennis S. O'Leary, M.D. "Many hospitals have diversified their services to address the longitudinal care needs of patients. Our evaluation activities must track the changing healthcare environment, and our name should appropriately convey to the public what we do."

The change in name will lead to the loss of the familiar "JCAH" acronym. "But we already refer to ourselves simply as the 'Joint Commission' and we would prefer this reference in the future, instead of an acronym," said Dr. O'Leary.

The Joint Commission accredits more than 5,100 of the nation's 7,000 general acute and psychiatric hospitals. Additionally it accredits more than 3,100 healthcare organizations in diverse settings.

Jacksonville cardiologist receives Founders Award

Roy Maynard Baker, M.D., a Jacksonville cardiologist for over 35 years, received the Founders Award from the Florida Chapter of the American College of Cardiology at its 1987 Annual Meeting held in Orlando on September 26.

The Founders Award is presented to the cardiovascular disease specialist who exemplifies the values and ideals of the founders of the Florida Chapter and is presented during the annual meeting each year.

Dr. Baker currently serves as Secretary/Treasurer of the Florida Chapter.

Hollywood doctor honored by peers

Stanley I. Margulies, M.D., from Hollywood, received special recognition from his peers during the convocation ceremonies at the annual meeting of the American College of Radiology, Tuesday, September 29, in San Diego, California. Selected for his outstanding contributions to the field of radiology, Dr. Margulies was named as one of the 104 fellows by the College's Board of Chancellors.

Fellowships to the College are awarded for significant scientific or clinical research in the field of radiology, or significant contributions to its literature. Criteria for selection also include performance of outstanding service as a teacher of radiology, service to organized medicine and an outstanding reputation among colleagues and local community as a result of long-term superior service.

Prospective fellows must be active members of the American College of Radiology for five years and be nominated by two fellows of the ACR, preferably in the same chapter area. Nominations are then reviewed by a committee before going to the Board of Chancellors for final approval.

ENCORES!

In Response

In a recent article published in the Monday, July 20, 1987 issue of *The National Law Journal*, Eugene I. Pavalon, president of The American Trial Lawyers Association, states that "the medical malpractice insurance problem, which does exist, can and should be corrected."

The article is replete with erroneous information and geared to the belief that "the so-called malpractice crisis is not a crisis but an insurance problem that only affects a few medical specialties." This false assumption is the basis for his cure to the problem.

Mr. Pavalon attempts to establish a conciliatory tone calling for mutual cooperation to resolve this admitted problem but offers unacceptable premises to reach his conclusions as to how to effect a cure. Although attempting to offer us an olive branch to accept his solutions, he wants "to lay down the gauntlet to the medical societies." I do not recall, from my boyhood readings, that laying down a gauntlet before King Arthur was considered as being an offering of peace.

For 12 years, the ATLA has been blind to the bleeding sustained by the public and the medical profession and deaf to our cries for help. Now that the public is aware of the truth and the problem has reached catastrophic proportions, especially in South Florida, the ATLA continues trying to protect the deep pockets for the handful of its members who have caused this entire problem instead of doing what is right.

Mr. Pavalon's solution is to have low risk physicians pay more in premiums so that those in higher risk specialties will pay less. He shows no consideration as to the outrageous increased percentage of gross income that these premiums would unfairly place on low risk physicians who don't generate enough income to afford what they're paying now. He says to pool the risks and bleed the public further, but do not dare limit our access to your deep pockets.

Mr. Pavalon, we are willing to "cool the rhetoric" or pick up your gauntlet but the choice is really yours. We and the public are simply sick and tired of paying exorbitant malpractice premiums to keep some of your members extremely rich. It's as simple as that! Let me remind you, sir, lest you continue to forget, that 12 years ago, your organization (the ATLA), told us we had no liability insurance crisis. You were wrong. You finally realized that we did have a crisis and it was one of the many causes for rising medical costs to the public. At that time, the ATLA rapidly turned face and blamed the problem on the fact that too many doctors were allegedly committing too much malpractice. But, you were wrong again.

When many businesses and industries began to fold because of the unaffordable costs of liability insurance, the ATLA wisely realized that it couldn't be due to doctors committing too much malpractice, so they decided to blame all the problems on the insurance companies. When the ATLA found out that the non-profit doctor owned and doctor operated liability insurance companies were sustaining the same losses and thus charging the same high premiums as the private companies, they reached a loss as to who to point their finger at.

Well, Mr. Pavalon, let me make it as clear as a boy from Brooklyn can make it. The problem lies in too high jury awards, exorbitant and obscene attorney fees and too many frivolous suits. All of these factors are directly related to your profession.

The ATLA must stop pointing their finger where it does not belong. Instead, they must direct their distal digit at themselves and at the few in their organization who have caused, fired and fueled this pathetic situation. Start, Mr. Pavalon, by CLEANING YOUR OWN HOUSE and along the way give some consideration to the needs of the public and the medical profession instead of your own pocket.

Creating another pool (shades of the Patient Compensation Fund) is not the answer and is totally unacceptable. There's only one of two answers: either take malpractice out of the tort system and put it into contract law such as workers compensation, or have meaningful tort reform with controls on attorney's fees, return of mediation panels, abolishment of joint and several liability, structured settlements and a $100,000 cap on non-economic damages. Ensure that the vast majority of monies awarded for actual damages goes to the injured party where the money rightfully belongs.

The outrageous, disgraceful and self-degrading remarks made during the opening scenes of Ted Koppel's "Nightline" show about the entire medical profession by Mr. J. B. Spence, one of this nation's most notorious malpractice attorneys, is reason enough why the ATLA must clean house before calling for a truce. The biting remarks in Mr. Pavalon's article, such as "the public should not suffer knee jerk responses to the demands of a privileged class to reduce their liability etc. . . ." and "doctors want to force patients to receive less than full compensation" is a further sign of irresponsibility on the part of the ATLA, and expresses a total lack of any knowledge of the problem or of any concern for a meaningful and lasting solution.

Mr. Pavalon, let the gauntlet temporarily lay where you dropped it, but heed the words of Arnold Toynbee, who said, "Life and law must be kept closely in touch, as you can't adjust life to law, and you must adjust law to life. The only point in having law

is to make life work. Otherwise there will be explosions."

Richard L. Glatzer, M.D.
President
Dade County Medical Association

Reprinted with permission from *Miami Medicine*, September 1987.

My worst successful case

This newsletter can offer, of course, no guarantees; but depending on our ability to cajole a series of reminiscences out of susceptible reminiscees the following article will be the first of that series. It is the editor's hope that the article might be thoroughly self-congratulatory. Heaven knows, we need an opportunity for a little of that, from wherever the source if even ourselves! The predicate is that deep within the nearly unconscious of every practicing physician and surgeon there lurks a fearful case, with serious issues even unto life and death, hanging by a thread. But by hook, crook, luck, or expertise, all comes out well in the end! Of such cases the editor hopes we may hear from the occasional member of our Society.

After completing my rotating internship at the Royal Victoria Hospital in Montreal, which included only a mere modicum of surgery, I spent three years on the south coast of Newfoundland dispensing a few medications, pulling teeth, and performing a very modest amount of veterinary surgery. The outpost was one of distinctive isolation, without roads, television, telephone, and only a few electrons to pierce the nocturnal darkness. I quite glibly forget everything I had learned in medical school and internship, but I was happy; and so decided to plumb further terra incognita, in due course obtaining the post of sole physician and surgeon to the mission hospital at Namitete, Malawi, East Africa.

The nuns who ran the hospital, impeccable and jolly sisters of a Franco-Austrian nursing order, knew everything, and they easily assimilated my ignorance, with the exception of surgery. They dealt confidently with leprosy, malaria, Bilharzia, and noxious worms, but understandably were limited in their surgical skills. They needed a real doctor. I put on my brightest face, and was more than kindly received.

It was in this setting that my worst, most successful case occurred. The single operating room was endowed for anesthetic purposes with a blood pressure cuff, and some cans of ether. The instruments were old, having come from Germany by way of one of Rommel's Panzer divisions. I could not help but look with a certain degree of awe upon the beautifully fabricated chest, painted in the field green of the Wehrmacht, marked with an iron cross and the gothic letters denoting the division of the Afrika Korps to which they had been attached. With these came a number of surgical texts, dating from the 20s and 30s, also in what appeared to me to be medieval German, but thankfully with some pictures. I was, as a surgeon, ready for what might come by the very barest.

In due time what came, in a cart pulled by a great oxen, was a young girl, in her teens, hugely distended, tympanitic as a kettle drum, and about as tight. Consulting the pictures in my German text, I saw immediately that the Afrika Korps had never in their experience had to deal with anything of such an ilk. The laboratory work up was performed, consisting of a hemoglobin which, as usual, was about 6. We cranked up the old, German x-ray machine, also painted Wehrmacht green, a portable unit that looked like a cross between a large standing bird and a machine gun. It shed, I was sure, particularly deadly quantities of assorted rays, but contrived to show dimly that the girl's abdomen was distended terribly. We had to operate!

"Prepare the patient," I cried, wondering if there might be any preparation left over for myself as well. The sisters, thrilled with the prospect of having a real doctor doing real surgery were all too swift in their chores. Too soon the patient, as T.S. Eliot would have it, was like a sunset, "etherized upon a table." Attempting to look like Theodor Billroth I donned surgical garb of spotless white, white cap, mask and antique rubber gloves. The wet season was beginning; rain began to fall, drumming on the tin roof. There were a couple of leaks but they did not actually drip on the patient. The most interesting drip was that of the ether onto the cotton mask. My own tummy felt a bit queasy, but there it was, the moment had come.

When I made my incision through the thinned out abdominal wall I had vague notions that there might be a bit of pressure therein; but was in no way whatsoever ready for the explosion of various loops of bowel that seemed to flood the table and, from my perspective, the room itself. I was totally unprepared that anything so huge could have been confined in so small a cavity! As the patient's intestines billowed about the room I suddenly felt a bit light myself; a telltale clamminess swept over me, the bottom of my stomach seemed occupied by its own alien horror, my knees felt weak and my senses giddy.

In the nick of time before the surgeon fainted, he said, maybe even in German, "This is a hard problem and I must think about it a bit." By pacing the floor thoughtfully I managed to pump just enough blood from my extremities to my left, middle cerebral artery, barely permitting my enfeebled organism to go through the necessary sundry motions of not frankly collapsing. I crept back to the OR table, appalled by

this pile of bowel. I could make no sense of it. I was vaguely aware that the African was somewhat more susceptible to volvulus, and thought this must be a hideous volvulus. I found something that appeared tremendously twisted, but nothing worked either clockwise or counter. Something had to be done.

Well, I made some otomies, and with little red tubes and a syringe tediously decompressed various lengths of intestine. I brought the major area of distension up to the peritoneal wall and put in a few tacking stitches, bringing the rubber tube out of her flank as an ostomy. It took, even so, some leger-demain to tempt the bowel back into the peritoneal cavity; and it crossed my mind that perhaps I should simply cut off half of it. But even if it had made sense I was not up to it, and so persisted, finally getting the abdomen closed with a series of whomping sutures.

I Fled.

The rains ceased. A mellow dusk, vividly red and yellow settled in the west exactly as it should out of Africa. I decided not to look at the patient until morning, and was swallowed up by darkness. I had a glass of wine with one of the fathers — they ran a bricklaying and carpentry school at the mission — on the verandah of their comfortable quarters, watching the moon come up as always, and the stars as bright as in any novel when the need arises. Father Tony was comforting, and philosophic. I saw Sister Pia do her rounds at 11, with a kerosene lamp, but I resolved to know no more, since I could do no further.

And then, lo! the next morning the patient was smiling, the abdomen was almost flat, she had no fever, and she was alive! I took the tube out in a week, after she had started eating again, and she went home to her village. She had survived, and I had not quite fainted.

Charles Moore, M.D.

Reprinted with permission from *CAP SCAN, Bulletin of the Capital Medical Society,* August 1987.

Are you having fun?

Theodor Billroth was the most innovative surgeon of his day, and perhaps the greatest medical teacher of the 19th century. By the age of 40, he had achieved international acclaim. Yet he wrote to a friend:

"The practice of my art does not make me happy. I can't even say that I am satisfied with my best surgical results. My ignorance, my failures, torture and bother me and I often damn the whole of surgery."

Judging from the comments of my colleagues, things haven't changed much during the past hundred years! Many of you with distinguished records have been heard complaining that medicine just isn't "fun" these days. This leads me to wonder: was it ever?

Searching my own experience, the answer would be "no." My own medical school years were simply an ordeal; my internship a tremendous challenge, which afforded me much satisfaction; my residency a time of expanding knowledge and confidence; my practice an application and "fine tuning" of skills so laboriously acquired. But "fun?" Other words — learning, growing, serving — are perhaps more appropriate. Medical life has been a constant struggle; a continual facing and tackling of problems, ever changing but never ending. My emotional response has been like a roller coaster: great pleasure in a problem neatly solved and great despair when the problem overwhelms.

Mountain climbers pursue their sport because they enjoy overcoming adversity and conquering a great challenge, but I've never heard them call it "fun." Their sensation on reaching the top is more of a quiet satisfaction than a pleasure. Are we not the same?

We may ask too much of our profession when we want it to be "fun." I think that it is too grim for that. A sense of accomplishment, of pride in a difficult job well done, may be the most that we should expect.

Fun is perhaps a more carefree thing, something reserved for the time we spend with our families, with our hobbies, when somebody else is carrying the beeper. What do you think?

Bill E. Barry, M.D.

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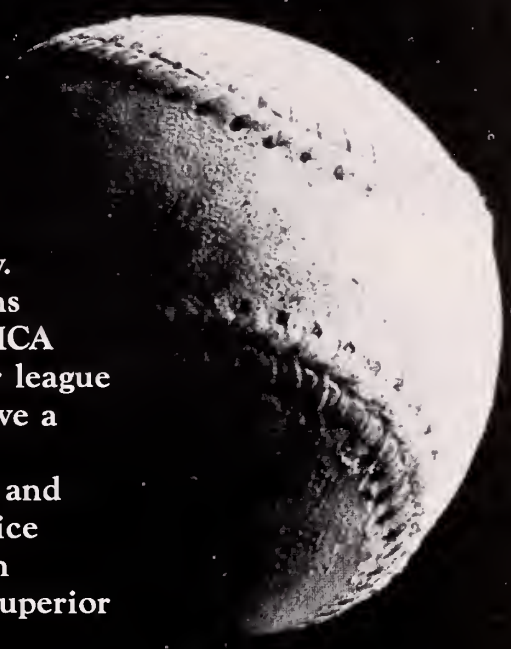
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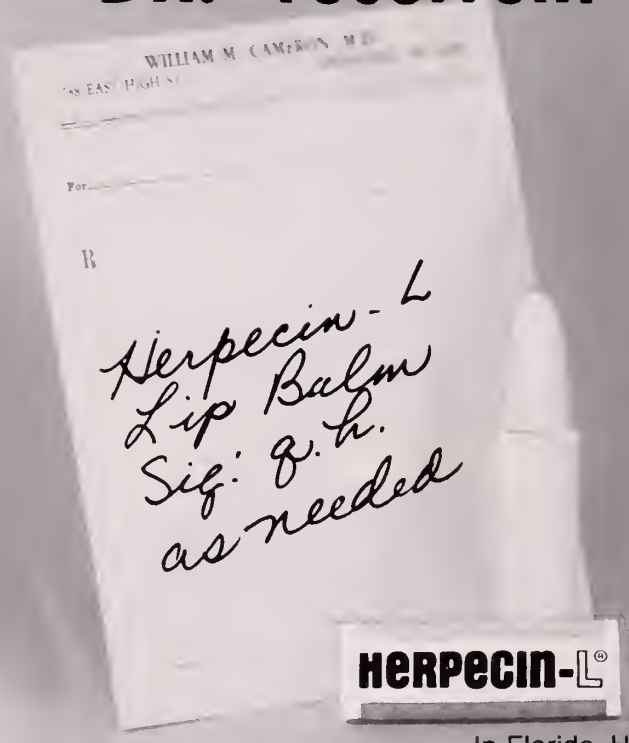
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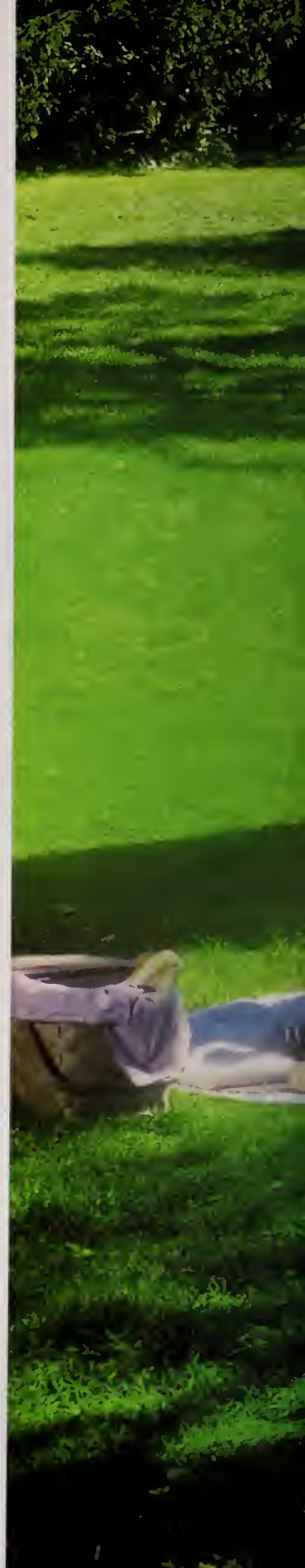


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References: 1. Feighner JP, *et al: Psychopharmacology* 61:217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Dixon R, Cohen J: *J Clin Psychopharmacol* 3:107-109, Apr 1983.

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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmia, heart block, stroke

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestations and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly.

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OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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PRECAUTIONS:
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Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
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Revised, April 1982. 5685

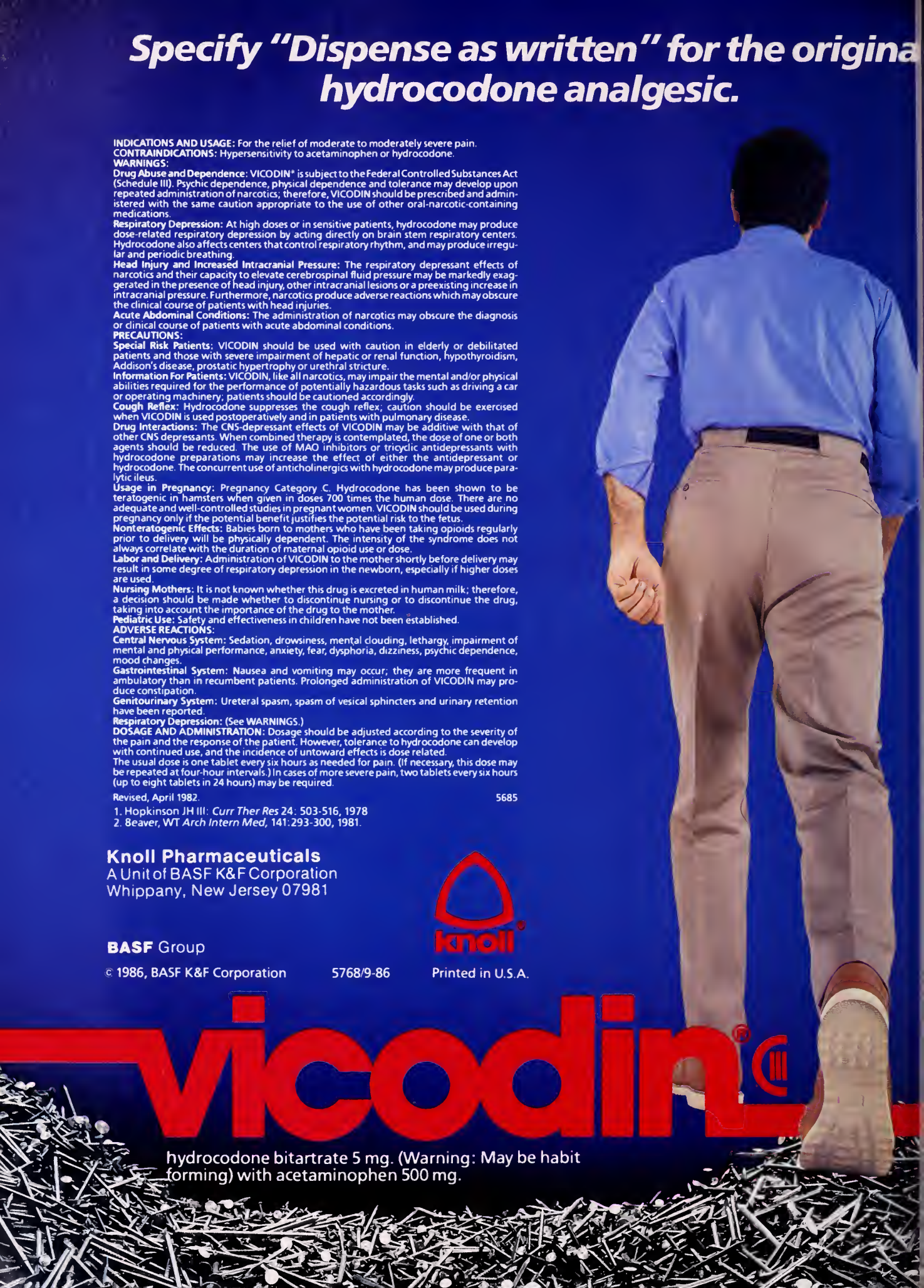
1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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BOOK REVIEW

Book Review Editor—F. Norman Vickers, M.D.

The Eighteenth-Century Campaign to Avoid Disease

by James C. Riley, 213 pages, price: $29.95.
St. Martin's Press, New York, 1987.

Endemic diseases and the more frightening epidemic diseases have puzzled humanity for millennia. Hippocratic theories about the effect of atmospheric and environmental factors on the human constitution prevailed for centuries. With the scientific enlightenment and the development of instruments to measure temperature, barometric pressure, and humidity and with Boyle's elucidation of the nature of atmospheric gases, these processes could be measured more accurately. With the scientific movement came measurement, not only of the physical and chemical properties of the environment but of life's processes (body weight, excreta, dietary intake) and of the effects of disease (mortality tables). It was hoped that when these measurements could be analyzed and generalized, they would lead to new discoveries about the nature of epidemics.

Riley's book explores the events of this movement in the 18th century and details the great works of the entire cast of characters, including such men as Thomas Sydenham, William Petty, John Graunt, John Arbuthnot, and Thomas Short. Riley further explores the work of the environmentalists — or medical geographers — on the Continent and in North America. In spite of a dazzling display of figures and data, their results never proved their theories. Riley has explored the many reasons for this failure. These scientists never lost faith in their theories and used them to inspire or reinforce the notion that environmental manipulation could reduce disease. Draining swamps and standing water, flushing streets and homes, improving air circulation in dwellings and cities, and reinterring dead bodies and dead material outside the cities were their main environmental weapons.

While these steps were being taken, the death rate fell remarkably and the world population rose at an unprecedented rate. Many have reasoned that these changes were due to an improved food supply and better nutrition and even to better medical care. The author's thesis is that the environmentalists were mostly responsible for the improvement in public health, since their methods all had the same goal — the elimination of what later medical science would identify as bacteria, viruses, and the all-important vectors of disease (rodents, insects, air droplets, water and food). This theory is well described and defended by the author, with full documentation; he includes numerous footnotes and an extended bibliography of English, French, German, and Dutch sources.

This book is a gold mine of information about 18th-century epidemic diseases and the medical and nonmedical scientists who tried to gather and analyze data on the whole spectrum of medical geography and climatology. The work will be greatly appreciated by students of the history of medicine, public health, epidemiology, demography, and environmental studies.

John J. Byrne, M.D.
Framingham Union Hospital
Framingham, MA 01701

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Auxiliary Liason Editor — Mrs. Charles (Lynn) Moore

The order changeth

"The old order changeth, yielding place to new" — *Tennyson*

In the Auxiliary's Articles of Incorporation, two of the purposes really form the basis for all of our volunteer activities. One states that we are to assist the Florida Medical Association, Inc., in its program for the advancement of medicine and public health. The second object is to promote health education; to encourage participation of volunteers in activities that meet health needs; and to support health-related charitable endeavors. Each year, faces and personalities may change, and methods and programs may vary; but our basic purpose and goals always remain the same.

I have chosen as my theme, "Better Health for Better Living." The health of the members of our communities is of prime concern to us. Our young people, especially, will be in the forefront of our efforts. Their use of drugs is still a challenge to be met, and we will continue to promote and support the "Just Say No" program, as well as other locally sponsored projects around the state. At the request of FMA President Dr. James G. White, who is greatly concerned with the increase in pregnancies among teenagers, the Auxiliary will also introduce programs for use in the schools to help combat this problem, as well as related diseases which are now affecting our youth in greater and greater numbers. The other end of the spectrum, our senior citizens, are not forgotten, and projects to support mental health, the handicapped, and other local services will have our volunteers' continued support.

The good health of our citizens is dependent upon well-trained people in the medical community. With the rising cost of education, our contributions to medical schools and students, through AMA-ERF, is a necessity; as are the scholarship programs, sponsored by state and local auxiliaries, which award financial aid to students in health-related fields.

Providing treatment for the whole family, not just the physician, is the ultimate goal of the Physician's Recovery Network (formerly the Impaired Physicians Program). It has long been recognized that the physician's impairment can be a very traumatic experience for the spouse and children. Duval County and its auxiliary will participate in a pilot program, designed to offer the help which the whole family needs. Current plans are to expand the state program to provide this assistance, and we expect to play a major role as a part of this support group.

The Auxiliary's commitment to the proposed constitutional amendment for liability reform will remain a priority obligation. I feel very fortunate that Immediate Past President Susan Marks, who has been so effective, has agreed to continue to spearhead the petition drive. We Auxilians, working together, will make the "Mission, Possible."

I hope to get to know each of you better during the coming year, and I look forward to working with you.

Mrs. Rex (Betty) Orr
President
Florida Medical Association Auxiliary

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NOVEMBER

Internal Medicine Update '87 November 1-6. The Colony Beach Resort. Contact: Murray Grossman, M.D., 315-473-4606.

Focus on Education November 2-4. USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Primary Care Update: Seventy-second Scientific Assembly, November 2-5, Diplomat Hotel, Hollywood. Contact: Ray W. Giffor Jr., M.D., (608) 257-6781.

Current Clinical Experience With Interferon, November 3, Knight Center, Miami. Contact: Neil Love, M.D. (305) 549-6867.

Thirteenth Annual Obstetrics and Gynecology Review Course, November 3-11, Doral Hotel on the Ocean, Miami. Contact: Patti Mundy. (305) 549-6944.

Infectious Diseases in the Elderly, November 4. Harbour Island Hotel, Tampa. Contact: Herman Chmel, M.D. (813) 974-3163.

Risk Management Conference, November 4, Howard Johnsons, Cocoa Beach. Contact: Brevard County Medical (305) 632-8481.

Protecting Your Medical Practice, November 4-6, University of South Florida. Contact: Pierre J. Bouis Jr., M.D. (813) 974-4296.

Advanced Applied Ultrasound in Obstetrics, November 5-7, Bowman Gray School of Medicine, Naples. Contact: Registrar, Ultrasound Center, Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, N.C. 27103 or call: (919) 748-4504.

Neonatal & Pediatric Respiratory Disease Conference, Sheraton Sand Key, Clearwater Beach. Contact: R. Lawrence Siegel, M.D. (813) 972-3131.

Screening for Cancer in the Primary Physician's Office, November 7, Tallahassee. Contact: Jill Carpenter (904) 877-6232.

Caduceus Risk Management, November 7, Sheraton Orlando, Orlando. Contact James Seigler, M.D. (305) 735-5430.

Echocardiography 1987, November 7-8, North Ridge Med. Ctr., Ft. Lauderdale. Contact: Barbara Stornant (305) 776-6000.

Procedural Skills for Primary Care Physicians, November 7-8, Sheraton Hotel, Dania, FL. Contact: Donald A. Berman, M.D. (305) 989-6650.

ACLS Provider Course, November 7-8, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

ACLS Instructor Course, November 7-8, USF College of Medicine, Tampa. Contact: J. Paul Michlin, M.D. or Daniel Cavallaro, M.D. (813) 251-6911.

Advances in Perinatology, November 8-14, St. Thomas, U.S. Virgin Islands. Contact: Eduardo Bancalari, M.D. (305) 547-5808.

Cardiac Transplantation, November 9, Sun City Hospital, Sun City. Contact: Donald Behnke, M.D. (813) 634-9284.

Care of the Sick Child, November 11-14, Palace Hotel, Lake Buena Vista. Contact: Colin J. Condron, M.D. (305) 841-5144.

Christ, Maimonides - Tourier Whole Person Medicine Conference, November 11-15, Tampa Marriott Airport, Tampa. Contact: William Reed, M.D. (813) 932-3688.

Coronary Heart Disease, November 12, Indigo Lakes Resort, Daytona Beach. Contact: Linda Cornelius, R.N. (904) 677-6900.

Flexible Sigmoidoscopy in the Diagnosis, November 12-15, Palace Hotel, Lake Buena Vista. Contact: Edward J. Kowalewski, M.D. (212) 517-7520.

Thirteenth Annual Ob/Gyn Pathology Review, November 12-15, Doral Hotel on the Ocean, Miami. Contact: Patti Mundy (305) 549-6944.

Nutrition in Pediatric Practice, November 13, Sheraton Tampa East, Tampa. Contact: Herbert Pomerance, M.D., USF Dept. of Pediatrics, 12901 Bruce B. Downs Blvd., Box 15Ce, Tampa, FL 33612. (813) 974-4214.

Diabetes and Kidney Disease, November 13, Harbour Island Hotel, Tampa. Contact: John Malone, M.D. (813) 974-4360.

The Distal Radioulnar Joint, November 13-14, Orlando. Contact: Paula Scheid, 3025 S. Parker Rd., Suite 65, Aurora, CO 80014. (303) 755-4588.

ACLS Instructor's Course, November 13-15, St. Augustine Technical Center, St. Augustine. Contact: Mrs. Margo Kinsey (904) 824-4401.

The Role of Stress in Mental Disorders, November 14, Marriott Harbor Beach Resort, Miami. Contact: Division of CME (305) 547-6716.

Flexible Sigmoidoscopy, November 14-15, Sonesta Beach Hotel, Key Biscayne. Contact: John P. Christie, M.D., (305) 687-1367.

All America's Health '87, November 15-18, Curtis Hixon Convention Center, Tampa. Contact: Pierre J. Bouis Jr. M.D., (813) 974-4296.

Medical/Legal Risk Management for Ophthalmologists, November 19, USF College of Med., Tampa. Contact: Roger Gstalder, M.D. (813) 974-3170.

Clinicopathological Exercise, November 19, Lykes Memorial Hospital, Brooksville. Contact: Kate Lacey (904) 799-0135.

Series on Diagnostic Parasitology, November 19-21, Devetec Building, Sarasota. Contact: Donald L. Price, Ph.D. (813) 351-1454.

16th Annual Cardiopulmonary Seminar, November 19-22, Sheraton Sand Key, Clearwater. Contact: James Eutzler, D.O. (813) 586-7103.

Choices in Cancer Care, November 20-21, Embassy Suites Hotel, Ft. Lauderdale. Contact: Cheryl Barillari (813) 253-0541.

Eleventh Annual Seminar of the Florida Association of Pediatric Tumors, November 19-21, Holiday Inn Crown Plaza, Orlando. Contact: Cindi Butson, P.O. Box 13372, University States, Gainesville, FL 32604. (904) 375-6848.

Perinatal Conference, November 21, 1987. Hilton Hotel, Ft. Walton Beach. Contact: Anne Kidwell (904) 863-4160.

Small and Large Defects, How I Repair Them, November 24, Boca Community Hospital, Boca Raton. Contact: Larry D. Garland, M.D. (305) 547-6716.

ACLS Provider Course, November 28-29, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

DECEMBER

Gastrointestinal and Hepatic Oncology, December 2-5, Lake Buena Vista, Contemporary Hotel. Contact: H. Worth Boyce Jr., M.D. (813) 974-2034.

Anxiety Disorders, December 3, Hyatt Regency, Tampa. Contact: Maureen McShane, M.D. (813) 254-1020.

Clinical Allergy & Immunology for the Practicing Physician, December 3-5, Buena Vista Palace, Lake Buena Vista. Contact: Richard F. Lockey, M.D., (813) 972-7631.

1987 Neuro-Opthalmology Course, December 3-5, Key Biscayne Hotel, Key Biscayne. Contact: Gaby Kressly (305) 326-6031.

Innovative and Controversial Strategies in Rehabilitation, December 3-6, Sheraton Bal Harbour, Bal Harbour. Contact: John H. Bowker, M.D. (305) 547-6716.

Diagnosis & Management of Respiratory Diseases, December 4-6, Boca Raton Hotel, Boca Raton. Contact: Karen DeBont, (800) 421-3756.

Risk Management Seminar, December 5, USF College of Med., Tampa. Contact: P.J. Bouis Jr., M.D. (813) 974-4296.

Basic Trauma Life Support Provider Course, December 5-6, USF College of Med., Tampa. Daniel Cavallaro, M.D. (813) 251-6911.

1987 FINA World Medical Congress, December 5-8, Justus Aquatic Center/Radisson Hotel, Orlando. Contact: Allen Richardson, M.D., (303) 578-4575.

Nonsexual Transmission of AIDS, December 6, Tampa. Contact: Barry Bercu, M.D. (813) 892-4233.

Emergencies in Internal Medicine, December 6-12, St. Thomas, Virgin Islands. Contact: Laurence B. Gardner, M.D. (305) 547-6716.

Special Topics in Diabetes Management, December 7, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Medical Risk Management, December 12, TBA, Jacksonville. Contact: Ronna Davis, P.O. Box 12099, Tallahassee, FL 32317. (904) 385-4935.

Risk Management Symposium, December 12-13, Peabody Orlando Hotel, Orlando. Contact: ASPRS, 233 N. Michigan Ave., –1900. Chicago, IL 60601.

A Case Study Approach to Risk Management and Malpractice, December 18-19, Sheraton, Bal Harbour. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

JANUARY

Chest Pain - The Great Mimic, January 9, Mt. Sinai Med. Ctr., Miami Beach. Contact: Esther Cohen, (305) 534-2916.

Advanced Vitreoretinal Surgery Course, January 14-16, Sarasota. Contact: Miguel Arcacha, M.D. (813) 952-0900.

Workshop in Clinical Hypnosis, January 14-17, Las Palmas Hotel, Orlando. Contact: Charles B. Mutter, M.D. (305) 547-2000.

33rd Annual Cardiovascular Seminar, January 15-16, St. Petersburg Hilton, St. Petersburg. Contact: Melissa S. Crater, (813) 867-5000.

Advances in Neurology, January 17-23, South Seas Plantation, Captiva Island, Ft. Myers. Contact: Millie F. Walden (904) 374-6058.

Magnetic Resonance Imaging, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Lipo Injection Technique, January 19, 1988, University of Miami, Miami. Contact: Larry D. Garland, M.D. (305) 547-4477.

20th Annual Postgraduate Seminar in Pediatric and Adult Urology, January 21-23, Doral Beach Hotel, Miami Beach. Contact: Charles Lynn, M.D. (305) 547-6596.

USF Contact Lens Course, January 22-23, Lincoln Hotel, Tampa. Contact: Charles Slonim, M.D. (813) 974-4360.

Drug Therapies in Diabetes Management, January 23, Hyatt Regency, Tampa. Contact: John Malone, M.D. (813) 974-4360.

5th Annual Doctor's Hospital Winter Seminar, December 23-30, Vail, Colorado. Contact: George T. Venis, M.D. (305) 856-6121.

Problem Oriented Approach to Vitreous Surgery, January 25-27, Biscayne Bay Marriott, Key Biscayne. Contact: Karl Olsen, M.D., University of Miami, Dept. of Ophthalmology (305) 326-6031.

Magnetic Resonance Imaging, January 25-28, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

20th Post Convention Seminar, January 25-28, Acapulco Princess Hotel, Acapulco. Contact: Charles Lynne, M.D. (305) 547-6596.

12th Annual Halifax Pastoral Care Institute, January 28-30, Halifax Hospital, Daytona Beach. Contact: Chaplain James Smith, (904) 254-4138.

Arrhythmias: Interpretation, Diagnosis and Management, January 29-30, Bahia Mar Hotel, Ft. Lauderdale. Contact: Deborah Wilderson 1-800-421-3756.

Vail Conference in Anesthesiology, January 30-February 6, Vail, Colorado. Contact: Brian Craythorne, M.D. (305) 547-6411.

FEBRUARY

13th Annual Review and Recent Practical Advances in Pathology, February 1-5, Fountainbleu, Miami Beach. Contact: Marie Valdes-Dapena, M.D. (305) 549-6437.

Current Concepts in Cardiovascular Disease, February 1-5, Buena Vista Palace Hotel, Orlando. Contact: Clarence Shub, M.D. (507) 284-2511.

Vail Symposium in Intensive Care, February 6-13, Vail, Colorado. Contact: Brian Craythorne, M.D. (305) 547-6411.

Current Clinical Concepts in Reproductive Endocrinology and Perinatology, February 8-10, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

20th Miami Winter Symposium, February 8-12, Hyatt Regency, Miami. Contact: W.J. Whelan, M.D., University of Miami, Dept. of Biochemistry (305) 547-6265.

Risk Factors for the Development of Skin Cancer and its Treatment, February 9, University of Miami, Miami. Contact: Larry D. Garland, M.D. (305) 547-4477.

Cardiology at Walt Disney World, February 11-14, Contemporary Resort Hotel, Lake Buena Vista. Contact: Scott Greenwood, M.D. (305) 843-1330.

14th Annual Fred J. Woods Lecture Series, February 12-13, St. Josephs Hospital, Tampa. Contact: Ralph Jensen, M.D. (813) 877-3682.

Magnetic Resonance Imaging, February 15-19, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Conference on the Beach, February 15-20, Holiday Inn Surfside, Daytona Beach. Contact: William G. Tomson, M.D. (904) 254-4167.

Special Topics in Diabetes Management, February 16, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Reproductive Organs Abnormalities Symposium, February 17-20, Vail, Colorado. Contact: James Ingram, M.D. (813) 974-2088.

Sarasota Vitreoretinal Update Course, February 18-20, Colony Beach Resort, Longboat Key. Contact: James Kingham, M.D. (813) 921-5335.

10th Annual Pulmonary Winter Course, February 18-21, Contemporary Hotel, Lake Buena Vista. Contact: Richard T. Doggett (904) 743-2933.

Pediatrics for the Practitioner: Update on Pulmonary Diseases, Sheraton Tampa East, Tampa. Contact: Herbert H. Pomerance, M.D. (813) 974-4214.

Health Care for the Elderly, February 19-20, Radisson Hotel, Orlando. Contact: Eric Pfeiffer, M.D., USF Med. Center (813) 974-4355.

Pediatric Dermatology CME Tour, February 19-March 7, India. Contact: Mr. Frank Martin 1-800-243-5030

Eyelid Surgery: A Basic Course for the Practicing Physician, February 20, USF College of Med., Tampa. Contact: J. Justin Older, M.D. (813) 971-3846.

Radiology in Seville, February 20-27, Seville, Spain. Contact: Lucy R. Kelley (305) 674-2681.

Breast and Thyroid Surgery: Current Controversies and Management, February 21-23, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

15th Annual Symposium in Pediatric Nephrology, February 21-25, Sheraton Bal Harbour Hotel, Miami Beach. Contact: Pearl Seidler (305) 549-6726.

Internal Medicine 1988, February 21-26, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bocles, M.D. (305) 547-6063.

Magnetic Resonance Imaging, February 22-28, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

February Course in Electrocardiography, February 29-March 2, Marriott Hotel, Boca Raton. Contact: Jules Constant, M.D. Cardiac Study Fund, Box 114, Hiler Branch, Buffalo, NY 14223 (716) 836-5172.

MARCH

20th Teaching Conference in Clinical Cardiology, March 2-5, Sheraton Bal Harbour, Bal Harbour. Contact: Michael S. Gordon, M.D., Ph.D., University of Miami (305) 547-6716.

Mid-Winter Seminar in OB/GYN, March 3-5, Don CeSar Resort, St. Petersburg. Contact: James Ingram, M.D. (813) 974-2088.

9th Annual Mammoth Mountain Emergency Medicine Ski Conference, March 6-11, Mammoth Lakes, Calif. Contact: Medical Conferences, Inc. 1-800-457-2777.

Cardiovascular and Diabetic Therapy, March 7-9, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

Wound Dressing/Retinoic Acid March 8, Univ. of Miami, Miami. Contact: Larry D. Garland, M.D., P.O. Box 016960, Miami, FL 33101

Selected Issues in Adolescence, March 11, Harbour Island Hotel, Tampa. Contact: Herbert Pomerance, M.D. (813) 974-4214.

The Journal of the Florida Medical Association, Inc.

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FAMILY PHYSICIAN WITH OB — VERMONT. Lovely community in the heart of ski country with excellent rural health center. Join two physicians. Enjoy salary plus full benefits. Vermont's lifestyle at its best. Send CV to New England Health Search, 63 Forest Avenue, Orono, Maine 04473 or call 207-866-5680.

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OUTSTANDING NEW OPPORTUNITY in metropolitan Atlanta, Georgia. Wesley Woods Geriatric Hospital - Geriatric Affiliate of The Robert W. Woodruff Health Sciences Center of Emory University is unique in concept and design. 100-bed acute care hospital includes a medical unit, an Alzheimer's Disease/Dementia unit, a psychiatric unit, and an assessment unit attached to central clinical support area. Outpatient/evaluation services also available. Surgery performed at nearby major medical center. Candidates will be board eligible/board certified in Internal Medicine or Family Practice with a zeal for Geriatric medicine. Excellent compensation, benefits, and marketing support. Contact Amy Evitts at Tyler & Co., 9040 Roswell Rd., Atlantia, GA 30350. Call (404) 641-6411.

OB/GYN NEEDED, BC/E. Join busy OB/GYN in new Women's Comprehensive Health Care Center. Ground floor opportunity. Salary, malpractice paid. Growing service area population currently 90,000. 112 bed full service hospital. In Central California, Tulare offers family environment, abundant outdoor recreation, beautiful homes attractively priced, good schools, restaurants, shopping. Easy access to all California attractions. Contact: Tulare District Hospital Physician Recruiting Office, P.O. Box 90112, Los Angeles CA 90009 (213) 216-2687.

INTERNIST OR NONINVASIVE CARDIOLOGIST: Southwest North Carolina, Family-oriented, semirural tourist town 1-2 hours from Asheville and Atlanta. Supported by less than 100 bed hospital, 3-county drawing area of 70K. Outdoor amenities: hunting/fishing/camping/skiing/etc. Compensation: 1-year guarantee/office space/set-up support. Contact Bob, Tyler & Co., 9040 Roswell Rd., Atlanta, GA 30350. Call 404-641-6411.

FAMILY PRACTICE — Great Opportunity to join a busy solo practioner in Lake Worth (West Palm Beach). Board Certification/Eligibility required. Contact Art Altbuch, M.D., 3918 Via Poinciana, Suite 5, Lake Worth, FL 33467, 305-433-1700.

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URGENT NEED: FL license doctors to fill needs of rapidly growing west coast community. Family Practice and internist. ALl hospitals are open staff. Send CV to P.O. Box 2411, Box C-1408, Jacksonville, FL 32203.

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POSITIONS AVAILABLE for Emergency Physicians in Ft. Lauderdale, Coral Springs, Vero Beach, Palatka, Clermont, Starke, Jupiter, and Tavernier Keys. Competitive compensation, flexible scheduling, no overhead or on-call duties. Professional liability insurance procured on your behalf. Please call or submit CV to Beth Barlow, Coastal Emergency Services, Inc., (800) 328-1038 in U.S. or (800) 432-3093 in FL; 2200 W. Commercial Blvd. Ste. 203, Ft. Lauderdale, FL 33309.

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BOARD CERTIFIED GENERAL SURGEON, as associate, private practice in Orlando. Send CV, references, photo to Box C-1366, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE or INTERNAL MEDICINE: Physician is needed for a busy practice in Hallandale, FL. Opportunity to buy in for the right person. Owner will consider financing. This office has a planned expansion over the next two years, and this represents an unusual opportunity. Reply Dr. Reinberg, (305) 458-0100.

INTERNIST — NORTHERN NEW HAMPSHIRE. State-of-the-art, small hospital in White Mountains of New Hampshire requires internist for multi-specialty group. Competitive salary plus incentives and benefits. Pleasant, small town with good schools. Close to famous Balsam's resort; short drive to Sherbrooke, Canada. Send CV to: New England Health Search, 63 Forest Avenue, Orono, Maine 04473, or call 207-866-5680.

OB/GYN - California, Central San Joaquin Valley, County Sponsored, Sixteen (16) Physician Multi-Specialty Group Practice with three (3) satellite locations, committed to high quality care, is looking for a board certified/eligible OB/GYN to provide ambulatory, delivery, and surgical services. The position provides a comprehensive benefit package and includes malpractice insurance coverage. Consider a semi-rural lifestyle with cultural amenities and easy access to metropolitan areas, the Sierra Nevada Mountains, and the Pacific Ocean. Salary $98,112 - 103,116 annually. Send CV to: Michael L. MacLean, M.D., Hillman Health Center, 1062 South "K" Street, Tulare, CA 93274, (209) 688-2015. Equal Opportunity Employer.

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MEDICAL PRACTICE opportunities available throughout the midwest and western United States. 30 attractive locations to choose from in metropolitan and rural areas. All with excellent salary and benefits. We will match your personal and professional needs with the right practice opportunity. Contact a member of the Health Manpower Placement Program at The Center for Rural Health Services, Policy and Research, 501 Columbia Road; Grand Forks, North Dakota 58201; or call 701-777-3262 collect. We make the intelligent match!

FAMILY PRACTICE - Blue Ridge Mts. of North Carolina. Board Certified FP needed to join 4 group practice. 12 miles from HCA managed hospital. Guaranteed salary incentive program. Send CV to Bakersville Clinic, P.O. Box 27, Bakersville, N.C. 28705 or call R. Duncan (704) 688-2104.

GENERAL INTERNIST, RHEUMATOLOGIST, NON-INVASIVE CARDIOLOGIST, PEDIATRIC SURGEON, AND OBSTETRICS & GYNECOLOGY: 40 physician multi-specialty Group in W. Palm Beach, FL seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 2 years. Send CV to Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 N. Olive Ave., W. Palm Beach, FL 33401.

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OB/GYN - Practice opportunity with established OB/GYN located here one year, (OB training at University of Miami and Thomas Jefferson University Hospital). Mountains, streams, and relaxed living in Middle Tennessee area. Mature (5 year) malpractice premium currently $21,000. Unusual opportunity with good growth potential, excellent living conditions, and great environment for family. Call Dr. Rene del Valle at (615) 473-6632 or Bill Summers, Hospital Administrator at (615) 473-8411.

B/C or B/E INTERNIST wanted for busy, established in practice in beautiful resort community on Florida's west central coast. Opening immediately available. Financial renumeration negotiable. Unique opportunity for the right individual. Respond to: Box C-1412, P.O. Box 2411, Jacksonville, FL 32203.

INTERNIST NEEDED, BC/E. Join busy OB/GYN in new Women's Comprehensive Health Care Center. Ground floor opportunity. Salary, malpractice paid. Growing service area population currently 90,000. 112 bed full service hospital. In Central California, Tulare offers family environment, abundant outdoor recreation, beautiful homes attractively priced, good schools, restaurants, shopping. Easy access to all California attractions. Contact: Tulare District Hospital Physician Recruiting Office, P.O. Box 90112, Los Angeles CA 90009 (213) 216-2687.

JOIN 3 ABOG CERTIFIED MDs in quality practice of OB/GYNs in lovely Conn. New office facility with sonography, mammography, etc. L.I. Sound, Boston, Providence, New Haven, NY. Fishing, skiing, etc, all within easy commute. Good schools, low crime rate, no state income tax, reasonable malpractice rates: trees, grass, 4 seasons, etc. Equal opportunity. Please write with CV: Norwich OB/GYNs Group, Inc., 125 Sachem Street, Norwich, CT 06360, ATTN: Len Green, M.D.

FAMILY PRACTICE: Great opportunity. Join solid group of four FPs in Central Florida. Low malpractice risk area. Abundant patients. Attractive town. Excellent school system. Marvelous place for family. Write: 306 S. Line, Inverness, FL 32652.

BC/BE FAMILY PRACTITIONER to join six physician department in a 38 member multispecialty group located on eastern Florida's treasure coast. Excellent salary, benefits and growth potential within this progressive organization. Send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1441, Jacksonville, FL 32203.

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EXCELLENT OPPORTUNITY FOR TWO BC/BE INTERNISTS AND TWO BC/BE OB/GYNS in rual setting. Prepared to offer generous guarantee with clinic space adjacent to 80-bed acute care hospital located 80 miles north of Mobile, AL in East Central Mississippi. For information, contact Administrator, Wayne General Hospial, P. O. Box 590, Waynesboro, MS 39367. 601-735-5151.

EMERGENCY MEDICAL GROUP, a progressive, physician-owned organization is seeking Full and Part-time Board certified/eligible and Family Practice physicians for openings in Southeast Florida. Competitive salary, paid malpractice insurance, benefits and attractive scheduling. Send CV to Emergency Medical Group, 1400 NW 12th Ave., Miami, FL 33136.

FAMILY PHYSICIAN: BC or BE for West Palm Beach practice. FL license necessary. Opportunity for future partnership. Call: (305) 967-0234.

DERMATOLOGIST NEEDED, BC/E. Excellent opportunity to establish private practice with no investment, guaranteed income. Growing service area population currently 90,000. Proven financial potential. 112 bed full service hospital. In Central California, Tulare offers family environment, abundant outdoor recreation, beautiful homes attractively prices, good schools, restaurants, shopping. Easy access to all California attractions. Contact: Tulare District Hospital Physician Recruiting Office, P.O. Box 90112, Los Angeles, CA 90009 (213) 216-2687.

ORTHOPAEDIC SURGEON, COLORADO: BC/BE orthopaedist to join solo practioner in quality, diversified, established practice. Community of 40,000, 50 minutes north of Denver. Excellent environment, access, medical community and equipment. Share call with third. Business arrangements negotiable. CV/contact: Earle T. Howard, M.D., 914 W. 6th., Loveland, CO 80537. 303-669-7100.

OB/GYN: Solo practitioner seeking partner in Houston, TX suburb. Supported by 200+ bed hospital with strong maternity/community awareness/marketing programs. Compensation package: $120K salary plus percentage, paid malpractice/health insurance/profit sharing/pension plan/relocation/CME/vacation. Coverage. Contact Bob Sweat, Tyler & Co., 9040 Roswell Rd., Atlanta, GA 30350. Call (404) 641-6411.

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November 14, 1987

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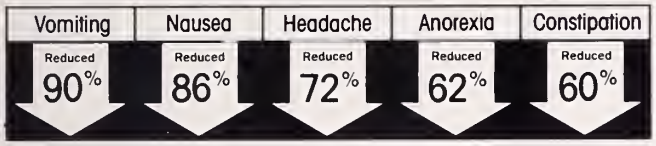
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- **Dramatic first-week reduction in somatic complaints[2]**

% Reduction in Somatic Symptoms[2]



- **Only ⅓ the dropout rate due to side effects of amitriptyline alone, although the incidence of side effects is similar[1]**

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.



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References: 1. Feighner JP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ

Limbitrol® (IV)
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage at three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
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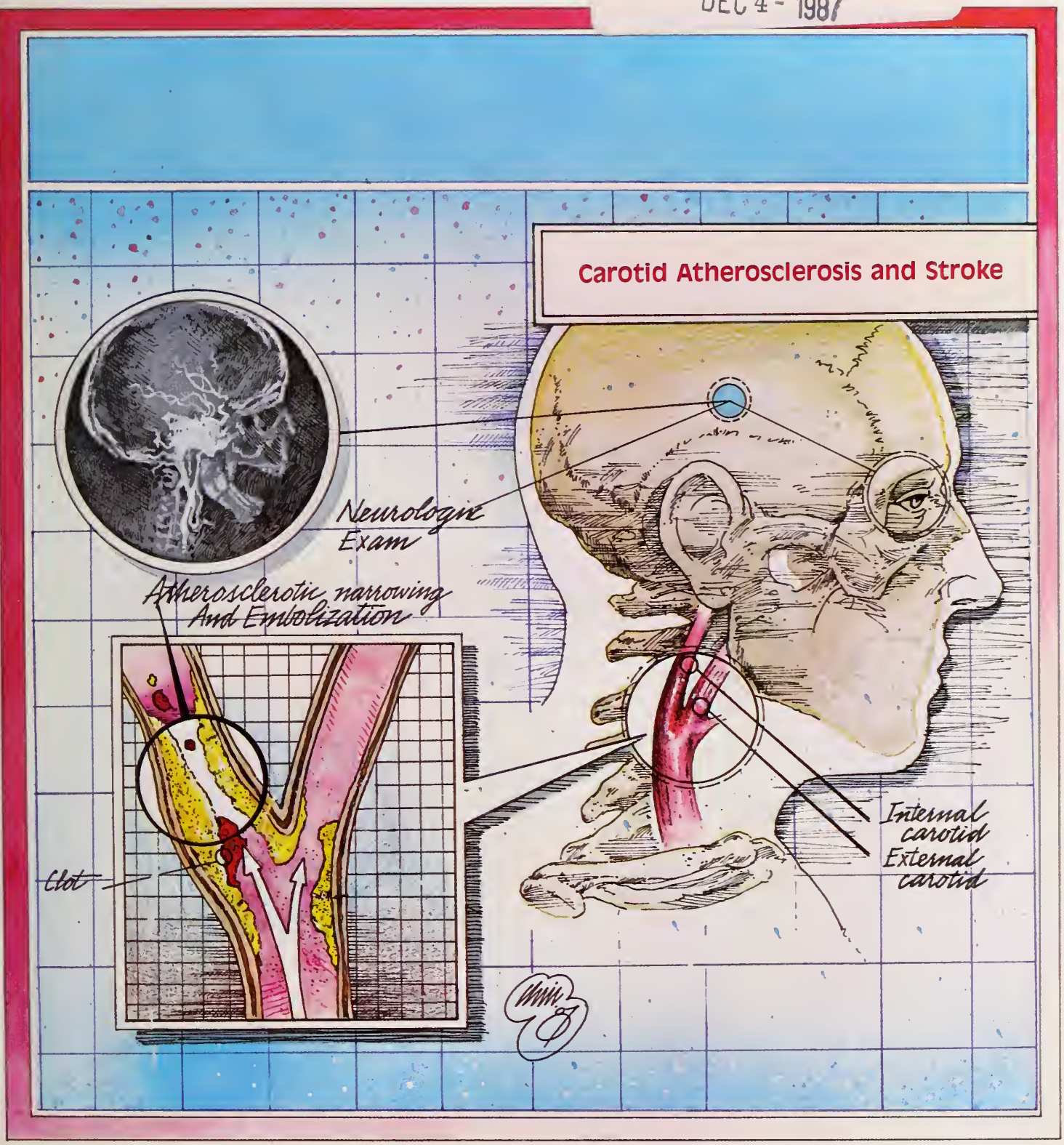
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CODEINE	X	X	X	X	X
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Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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The cover for this special issue of *The Journal* devoted to carotid atherosclerosis and stroke was designed by Christopher Armstrong. It depicts the two pathogenetic mechanisms whereby carotid atherosclerosis produces cerebral ischemia. These mechanisms are embolization usually related to an ulcerated plaque and a significant reduction in blood flow resulting from narrowed or occluded carotid arteries. There is also a representative carotid and cerebral angiogram, the most definitive method of diagnosing carotid atherosclerosis.

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Further Efforts on the PLI Crisis



Since our last visit here on the President's Page, several events have occurred regarding the professional liability crisis. On Thursday, October 22, John Thrasher, Dr. Lou Murray and I met with President Marshall Criser, Chairman of the Academic Task Force. We discussed in detail the preliminary report and the items that needed to be modified if the PLI crisis is to be resolved.

Don Jones, John Thrasher and I next attended what was supposed to be the final meeting of the Academic Task Force in Jacksonville on October 29. You are aware that the trial lawyers were successful in delaying this report for another week for reasons that were unclear except to forestall any changes in the current system.

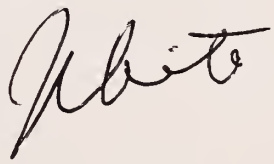
We then flew to Tallahassee to meet with Governor Martinez and he, too, was frustrated that we could not get a recommendation on the table for discussion. At the conclusion of the meeting, the Governor indicated that he leans toward calling a special sesion for January 1988 if this is acceptable to our physicians. He made a definite commitment to not combine the PLI and tax issues in the same session.

On November 5 we traveled to Palm Beach, Broward and Dade Counties to meet with the county presidents and executives. All agreed to support the Governor's decision to delay the special session until January.

By now you have seen the final recommendations of the Academic Task Force. We are DEEPLY DISAPPOINTED that the caps on general damages are too high, that trauma care is not addressed, and that the state wants to get into the quality assurance and peer review business. We are actively communicating with every county to rally our troops in support of MICA. You should each have received a packet that, if utilized properly, will get our message out to the public and our legislators.

We need to continue collecting petitions for our constitutional amendment. This is our ace in the hole that will do two important things: (1) It will keep our PLI problem before the public and (2) the pressure will be put on the legislature to pass MICA or something close to MICA.

Please remember that we will not succeed unless our entire membership AND spouses get committed to action. Without active grassroots support, we will fail. I know I can count on each of you.



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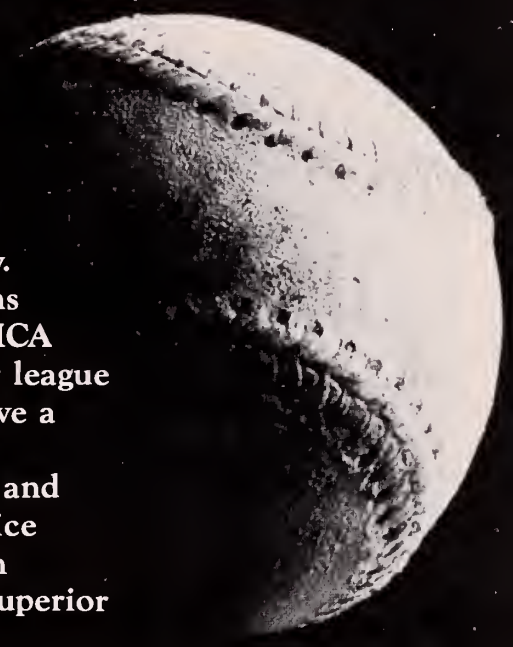
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*Men are required who have a **sense of obligation**, that feeling which impels a teacher to be also a contributor, and to add to the stores from which he so frequently draws.*

Sir William Osler, M.D.
Lecture on Teacher and Student
University of Minnesota, 1892



I wish to commend the contributing authors of this special issue, John A. Schwartz, M.D., William M. Blackshear Jr., M.D., Ronald G. Quisling, M.D., William Akins, M.D., Gerald S. Goldberg, M.D., Thomas B. Beach, M.D., and Peggyann Zaenger, Pharm. D., not only for their *sense of obligation* but also for their *enthusiasm* and *personal knowledge* of the subject matter about which they have written. Notwithstanding the complex and controversial aspects of the topics addressed, the authors have succeeded in providing us with a comprehensive summarization of current knowledge regarding the diagnosis and management of stroke-prone patients with carotid atherosclerosis. I congratulate the authors for their contributions to the "stores" of medical literature.

Finally, I want to express my sincere appreciation to the Editorial Staff of the JFMA, especially R.G. Lacsamana, M.D., Kathy Lundy, Tom Jarvis and Sissy Crabtree, for their willing support and cooperation during my tenure as Guest Editor.

Daniel B. Nunn, M.D.
Guest Editor

Getting No Respect

Most physicians who have had dealings with the government must now feel like Rodney Dangerfield: they don't get any respect. In the frenzy to save a dollar here and there and to salvage a sinking Medicare program, mindless bureaucrats from Washington have flooded physicians with a torrent of regulations that threaten to destroy the last vestige of mutual trust that exists between the two parties. One gets the unmistakable impression that Uncle Sam is out to coerce physicians into submission under the guise of containing medical costs.

Two recent regulations from the HCFA illustrate the deep distrust of physicians by the government. One of them requires physicians, who do not take assignments on elective surgical procedures costing at least $500, to give Medicare patients a written notice listing the type of procedure, the physician's estimated charge and the estimated Medicare allowance, and the patient's out-of-pocket expenses. The other regulation allows fiscal intermediaries for Medicare to require physicians to reimburse patients for what are deemed to be "medically unnecessary" services. Both regulations are an insult to the integrity of physicians and potentially can create deep wedges in patient-physician relationships.

It is ironic that an administration which embarked on a program of less government interference has found it convenient to saddle the medical profession with an overkill of regulations. These regulations, sad to say, have been counterproductive. They have eroded the independence of physicians, have adversely affected the quality of medical care by imposing cookbook medicine, and have burdened patients and physicians alike with endless bureaucratic nightmares. In addition, they have created a deep antipathy among physicians against the government.

The bureaucrats orchestrating this massive regulatory assault on the medical profession are acting on the premise that regulating physicians holds the key to containing medical costs successfully. This is a naive assumption. Physicians can control costs up to a point without sacrificing the interests of patients, but can do little to influence the course of inflation, the rising number of elderly Americans, the

increasing demand for medical care by the public, the advent of advanced technology, and an assortment of other things that all contribute to the nation's health bill. Physicians' fees make up only a small fraction of the yearly Medicare outlay, and even if charges continue to be frozen, such manipulation is unlikely to yield any substantial reduction in the total costs.

By failing to see that regulating medical practice does not work and will not work, bureaucrats continue to suffer from the delusion that piling more regulations will provide them with the magic potion to cure the ills of Medicare. Beyond curbing the excesses of a tiny fraction of unscrupulous physicians, the advent of DRGs, PROs, and Medicare assignment programs has not benefitted Medicare patients. To the contrary, these programs have created another massive, inefficient, and impersonal bureaucracy while subordinating the interests of patients to purely fiscal considerations. One does not need to go far to see the havoc wrought by the PRO legislation, for example. More than 40 hospitals across Florida have filed a suit against the HCFA with a litany of charges involving the state PRO in Tampa. Many of the charges are familiar to practicing physicians: inappropriate denials of hospital admissions, failure to do peer reviews, an interminably long appeals process, and failure on the part of the reviewers to communicate with physicians. What is happening in Florida, of course, mirrors what is happening elsewhere in the country.

It would be a tragic mistake for the government to assume that it can continue to regulate the medical profession while ignoring legitimate concerns by physicians. Most physicians share the government's concern for cost control and will work willingly toward that goal, but will not support policies that will jeopardize the interests of patients. The main focus of most government regulations, unfortunately, diverges from that of the medical profession, and a compromise is clearly out of the question for physicians. There is a growing suspicion that the government is bludgeoning physicians bit by bit in an attempt to eventually foist socialized medicine. Although that may happen, a majority of Americans already said they don't want any such thing. The government may yet respect that public sentiment, but please don't pass that on to Rodney!

R.G. Lacsamana, M.D.
Editor

Medical Residency Training — An Anachronism

Recently I have been reading the accounts of the efforts of several states to limit the number of hours a physician in training can work at a particular time. California and New York are both considering laws to limit residents to specified hours of working. Hooray for this! The residents would join other professionals such as airline pilots who are engaged in occupations where other lives are placed in their care and limit factors which compromise the ability of the professional to operate in a safe and efficient manner. It is time for the medical profession to join these other segments of society. It is certainly clear to all that the action of a doctor often determines whether a person lives, dies or is left with any disastrous consequences. The airline pilot has his hours of flying limited, has restrictions placed on certain medications before flight, and undergoes strict physical examinations. The goal of all these regulations is the safety of the passenger. Does anybody dispute this meticulous scrutiny and its intended purpose? Not very many and the reason is apparent. How can you legitimately complain when lives are at stake?

If for no other reason than the welfare of the patient, the medical profession should be behind any movement which calls for a limitation of hours that a resident works. The inherent danger of a doctor working 30 to 40 hours at one stretch or 90 to 120 hours a week should be obvious to all. It certainly has not been lost on patients and plaintiffs' attorneys as the number of suits against resident physicians has proliferated over the past few years. Inherent in almost all of the suits have been the accusation that the resident was exhausted at the time of the incident and not capable of making the critical decisions that demanded a clear head and complete concentration. Apparently many juries have believed this indictment and have often returned verdicts for the plaintiff. It is rather hard to convince the jury that you are able to come to a logical and correct decision after going without sleep for 36 hours.

Of course I would not agree with the approach taken by New York which wants the residents to have their pay reduced so the money can be used to hire more residents. The state is correct in its approach that hours should be limited. It is wrong in its approach that the residents should pay for it. The public municipality, whether it be state, county, or city, should pay for this if it takes place in a tax-supported institution. If private, the supporting entity should bear the financial responsibility.

It appears that organized medicine has been rather quiet on the entire subject and I believe that

this is the result of several factors. Many physicians seem to become emotional over the issue of the hours worked by residents. There is some nostalgia with many doctors regarding residency training. I am not sure if this represents a mystique or genuine belief that the way residency training is structured is the best way and should be left alone. After all, it has been that way since the early 1900s and has produced great doctors, so why change it? There are also those who approach the subject with a boot camp mentality and feel that residency training is akin to the rites of entering manhood practiced by various cultures throughout history. These physicians see some cleansing of the soul and a passage into the ranks of medicine by going through sleep deprivation and gruelling sessions by the attendings, sometimes bordering on cruelty. I hasten to add that not all residents are exposed to this. It depends on the institutions, the attendings and the chairman of the department under which the resident finds himself.

I am appalled when I hear the residency system defended by physicians with the exclamation that "if I had to go through it, then others should have to do the same." This rationale has not carried any weight in courts of law and should have no credibility with anyone.

Besides the fact that an overworked, exhausted resident could be a danger to the very person he is supposed to help, I can give two very pertinent reasons for revising residency training. One is the desensitization that becomes a part of the infrastructure that a resident builds as he goes through residency and which he will take into private practice. I have heard as a defense to the current residency system that a physician learns best under stress, that cardiogenic shock occurs at any hour, etc., etc. Of course, policemen, firemen, pilots and deep sea divers learn their respective professions by not working to exhaustion but by a carefully structured program. Medicine is no more stressful than any of these professions. What does working 36 hours and admitting 10-15 people accomplish but to make many of the admitted patients your enemy? We have all experienced the resentfulness, anger and lack of compassion which we see in our own actions when called to the emergency room after going without sleep for 38 hours to admit a patient to the hospital. I don't think any of us was happy to see that patient. Of course the patient may be a "great case" and the resident is exalted to greater heights of patient care to learn more about the "case". The patient may quickly be given the title of "another gomer" but a great case nonetheless and pass into the labyrinth of medical training lore. I am not a sociologist, but it appears that three to seven years of this type of mind-set puts patients into a category that a resident approaches with less sensitivity, respect and courtesy which one would customarily extend to another person.

The other reason that I feel is important to limit the number of hours a resident works is that medicine should recognize the inherent shortcomings of the present system, take steps to change it and not let out side forces take the initiative. Outside influences in this case would be the state legislatures. Unfortunately, medicine is once again letting a golden opportunity slip away. If our present system of 100-120 hour work weeks cannot be defended, and I do not think it can, then organized medicine should boldly step in and take the initiative for that change. I do not think it has. There are many reasons cited for not being more forceful, such as the finances and who is going to pay for this change. While this is a real problem, it is not the primary problem of medicine and it should not detour us from advocating change if we feel this is in the best interest of medicine and patient care. Let the politicians answer that question, but do not let them appear to take the initiative for change while medicine stands immersed with immobility.

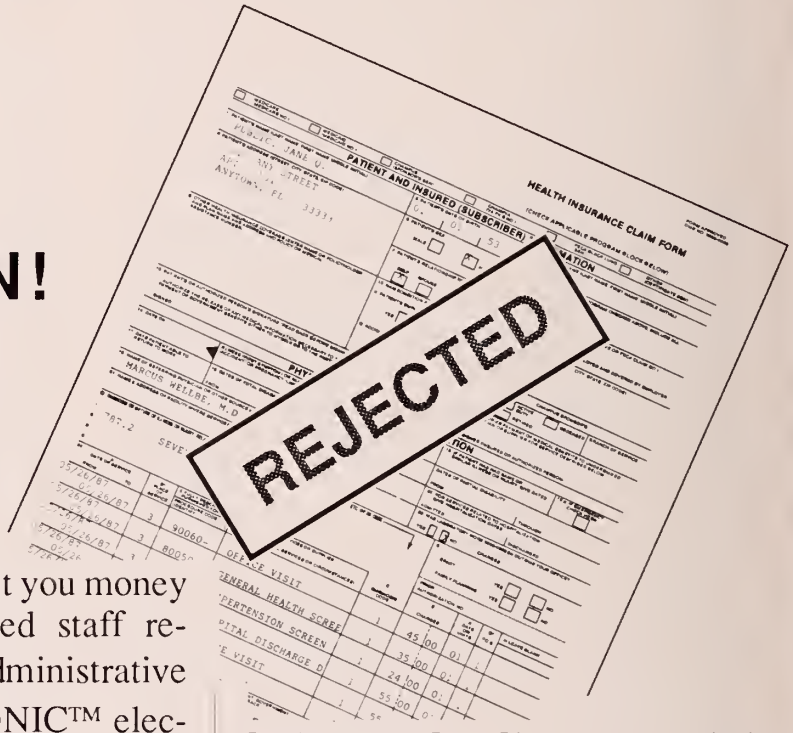
Medicine has too many times let outside forces take the initiative for rightful change. The most prominent example is the beginning of scientific formal education in the United States, which was ushered in by the Flexner Report of 1909. Many people think that medicine was the impetus for this change, but it was not. There were a few medical authorities with vision who advocated the strengthening of our medical schools, but the bulk of this change was caused by the Progressive Reform movement which swept the United States in the early 1900s and was made up of consumer groups, legislators and others who desired to protect the average citizen, which included having an adequately trained physician to take care of them.

The Flexner Report and the changes ushered in came about because other groups besides organized medicine initiated the change and medicine only joined in after being prodded by these other groups. Let us not make the same mistake again and let other forces initiate reform which would be for the betterment of medicine and patients.

H. Frank Farmer Jr., M.D., Ph.D.
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You have a great journal but I did not like your Editorial, "An Ill Wind Blows Across Medicine." It is not that I disagreed with its content or the writing style; I just think that we are dividing ourselves and fighting a fight against chiropractic care on one side, the lawyers on the other side and the government in the middle. Let us not divide ourselves too thin. I am not personally impacted by the chiropractic community anywhere near the degree that I am affected by the malpractice situation. Please do not waste the energies of the FMA or AMA fighting chiropractors who are licensed to practice their craft under state law. Let us direct our attention to the ever worsening medical legal problem that, if not stopped now, will drive me out of surgical practice in a short time.

Let me explain the predicament that orthopedic surgeons are in in the State of Florida. If one pays $75,000 a year for malpractice now and it goes up 40%, that will make a premium of $105,000 come January 1988. An additional 40% rise next year will put severe strains on our overhead and make it not worthwhile to perform surgery as of 1989. Put your mind to work on this problem and stop spreading the FMA too thin.

Philip M. Lascelle, M.D.
Sarasota

Editor's Note: *If Dr. Lascelle was paying attention, he would have noticed that* ***The Journal*** *has been spotlighting the PLI issue the past several months with editorials, letters and special articles. While I sympathize with him and others who are paying exorbitant malpractice premiums, I don't feel that physicians should close their minds to everything else just because of this issue. Medicine has many other concerns that demand attention; to ignore them would not be serving the best interests of physicians.*

Unsolicited Solicitations

An unsolicited attorney solicitation is a very serious breach of ethics that often results in the filing of spurious negligence suits that might otherwise have been settled out of court by the injured parties. Persons injured in accidents and those brought to hospital emergency rooms have become "fair game" to some trial attorneys, especially since these reports are considered "public records." Unsolicited solicitations are often very traumatic to the injured person and his family.

The United States Supreme Court has extended First Amendment protection to lawyer mail solicitation. The Florida Bar states that "an attorney may not solicit professional employment from a prospective client with whom the lawyer has no family or prior professional relationship in person or otherwise, when a significant motive for the lawyer's doing so is the *lawyer's pecuniary gain*. The term 'solicit' includes contact in person, by telephone or telegraph, or by other communication directed to a specific recipient and includes any written form of communication directed to a specific recipient."

When an attorney uses in-person solicitation or telephone or mail solicitation, there are several important facts that he may *not* be aware of: 1) whether the person already has an attorney; 2) whether the person has submitted a claim to an insurance company; 3) whether the person has undergone physical or emotional strain that might make the person unable to exercise reasonable judgment as to whether or not he wants the services of an attorney.

Since the advent of "Unsolicited Plaintiff Solicitations," injured parties are often urged to sue by some trial attorneys. These lawyers also do not want a special session of the Florida Legislature that might provide tort reform *unless* a "DEEP POCKET" is preserved.

Perhaps some trial attorneys are not aware of all the requirements of the Bar rule regarding unsolicited solicitations. We ask the Bar to clarify the rule and to discipline those attorneys who do not follow the rule.

David J. Lehman, M.D.
Member, Florida Legislature
1974-1984

Editor's Note: *In addition to what Dr. Lehman points out in his letter, there have been rampant press reports recently concerning solicitations by unscrupulous lawyers to families of airplane crash victims. The American Bar Association is embarrassed by these incidents and has promised to look into the problem.*

A Fiscal Note on Quality

Quality may be defined as the most efficient use of available resources. The JCAH defines quality as the degree of timely adherence to generally recognized contemporary standards of good practice with the achievement of anticipated outcomes for a given procedure or service. Physicians generally maintain that the quality of care in hospitals depends on the quality of the Medical Staff. Hospital risk managers are convinced that perceived quality reduces potential risk.

Consumers have the right to expect a reasonable degree of quality in health care products. Patients should demand and receive high quality medical care.

Physicians must advocate for patients the highest quality of medical care. It is incumbent that future physicians be able to advocate for consumer groups of patients in order to provide more than medical care. Physicians must involve themselves in health care to preserve quality. Employers and third party payers will demand high quality medical care.

In the current atmosphere of concerns for quality and cost several considerations come to mind. Prospective pricing fails to recognize the high cost of high quality health care. Future governmental payment plans may depend more on federal budget considerations than acuity of illness or quality of care. Governmental goals may be reached through regulation rather than the purchase of services for individual patients. If our government adopts capitation as a system of paying Medicare bills in an effort to reduce volume of care, as well as price, all physicians will have concern for the quality of care they will be able to provide to their individual patients. I do not believe quality can be persevered in a capitation system without a means test for Medicare beneficiaries. Patients who can afford it will simply have to pay more of their medical costs. We need to be prepared to control the high cost of new technology or limit its availability. Health care rationing, correctly defined, is already in place on an economic basis. The present attitude of more for less simply will not solve our basic problems.

To protect the quality of care hospitals and physicians must develop information systems that quantify quality. Quality once defined may then be used to educate legislators that whatever system used must be fair and maintain quality. We must not let our government develop a mindset that Medicare is a hospital support program instead of relating to the needs of individual patients.

Technology is not cheap. Hospitals with borderline margins may find it difficult to develop information systems to ensure quality when economic payback may be slow in coming. Quality may seem like a luxury when survival is at stake although quality is almost always cheaper in the long run. Many hospitals are using the system approach in an effort to solve this cost problem. It remains to be seen if bigger is really better in any field. Does economy of scale apply to our diverse regionalized health care business? Hopefully these questions will be answered in the near future. The greatest benefit to quality of multihospital systems may come in the form of identifying areas in which hospitals are able to survive and excel. Hospitals may not be able to raise their prices to shore up a weak bottom line due to limits set by payment systems. They will have to rely on competitive marketing to fill their empty beds at a time when more and more procedures follow their funding source to the outpatient department. Hospital outpatient visits exceeded hospital inpatient days for the first time in 1985. Marketers are just beginning on their learning curve understanding our conservative industry and its reluctance to change. Hospitals cannot risk testing services in the market place. The market will have to be identified before implementing services.

In many areas of the country local governments want to tax our not-for-profit hospitals. These public hospitals represent the country's only form of national health insurance. The mood of the country seems to dictate that the not-for-profit sector prove it deserves tax privilege. The federal government has created tax incentives to encourage development of HMOs and the for-profit sector in a misguided effort to increase competition and reduce costs. It should be clear by now that hospital costs go up in proportion to the competitiveness of the environment. Our economic system seems to place little value on social or people issues. Deregulation means we serve the sick that can pay us.

It is very likely that in the future all patients regardless of their pay mechanism will have to be responsible for a greater part of their hospital and medical bills. Physicians and hospitals will be obligated to educate patients, employers, our government, and other third party payers about the high cost of quality medical care. If choices must be made we may consider spending more on medical care and less on health care. Only 60% of the nation's health care dollar is spent on hospital care and physician services.

Will we create a future that includes access for the uninsured? Can health care become more than caring for patients who can pay us? Will patient care, education, and research define quality? Will we measure each other in terms of our outcomes? Will competence, compassion and communication be our goals? Who lives and dies will be largely up to us. Are we prepared to meet the challenge? Hopefully we are creating a future where the greatest service to all patients will be quality. This new future will belong to its most innovative architects. Is it possible that the time is right to create a new social dimension in our medical care delivery system?

Kenneth C. Henderson, M.D.
Mercer University School of Medicine
Macon, Georgia

New Treatment for Nocturnal Leg Cramps

The leg cramps referred to in this paper mainly involve the muscles from the knees down into the feet. The difficulty usually begins in the fifth decade of life, and increases in frequency until it occurs every night after retiring. I do not include in this paper the occasional cramp that may occur at odd times during the night.

The nocturnal leg cramps usually begin after having been asleep two or three hours. The cramps are relieved by sitting, standing, or walking. Hoping to get more sleep, you go to bed. The cramps soon return, and you repeat the above ritual to get relief. Finally in desperation, you sit in a chair and sleep.

I was able to obtain partial relief by taking Quinine Sulphate at bedtime, until I acquired an allergy to the medication. Some months later, my wife complained about heartburn after retiring. She has a hiatal hernia. I thought she might get relief if the head of the bed was raised nine inches on wood blocks. We sleep in a double bed. The result was she had no relief; instead, it was I who did not have a leg cramp all night. Needless to say, the wood blocks were not removed.

Several months later, I mused whether the things I thought had given me some relief before were really necessary, such as stretching the Achilles tendons, sleeping under extra warm covers, and medication. Each was eliminated one by one. Last, it was necessary to determine if the raised bed really gave the relief. The blocks were removed. The leg cramps promptly returned. Since that night the head of the bed has been raised nine inches on wood blocks.

J. William Peelen M.D.
Sarasota

Editor's Note: *Rejoice all ye with nocturnal leg cramps! Dr. Peelen's discovery is either a big bust or a glorious moment of serendipity. Let's hear from you.*

Pioneer's New Day

Come fellow physicians
time to pause and with collective brow
our noble ancestry recall.
A regal kinship, Hippocratic cord,
join us thru time.
Seasons like now enticing our discord
should harden our resolve
to protect and to heal the weak and sick.
A whisper of the Gods is still with us,
don't let it waste.
Cherish your knowledge, but with humble stance.
Abhor the mercenaries beating with haste
on our fraternal gates.
With history and tradition on our side,
must continue reaching for the skies
of achievement and hope.
Our torch, seemingly half extinguished, but intact,
must be rekindled before passing forth.

Roberto Llamas, M.D.
Chief, Pulmonary Medicine
Miami Heart Institute

Editor's Note: *We cannot wax poetic like Dr. Llamas but we think we get his message.*

How to Become Judgement Proof: It's the Only Hope You've Got

I present you with a constructive, practical approach to the malpractice mess. It is not the whole answer, but there is little else in sight. The opinions expressed are shared by many but do not reflect or imply any endorsement by this publication or its governing body.

A minimal working amount of liability or malpractice insurance should be carried for help with defense costs and nuisance suits. Past this level benefits are illusory. Claims ask for astronomical judgments exceeding affordable coverage. A lifetime of conscientious work can be stolen in one court day. Some states like New York have enacted reform. Florida is not yet one of them.

But there is a bright side. I am not a lawyer, but am able to pass on information which I have learned from my attorney, accountant, tax analyst, security and insurance sources. I must advise you to confirm with your own. A hundred years ago, laws were written to protect people from becoming paupers. Today a truly indigent person is less likely to lose all of his possessions than a physician. Those laws still work for all in the following areas:

RESIDENCE: A person's home is protected against creditors. Contents and assets are not, past $1,000.

TBE: Those do have a measure of protection if they are owned by you and a spouse as Joint Tenants With Rights of Survivors. Then JTWROS becomes TBE, Tenants By the Entirety. Everything should be listed as such.

WAGES: Wages of the head of a household are protected. A separate bank account labled "wages" must be established for *earned* income.

INSURANCE: The contents *and proceeds* of life insurance with cash surrender value and disability insurance are protected. This does not include term insurance, which is cheap but that's all. Today, better programs are competitive with other long-term investments, grow tax sheltered, and can be borrowed against without taxation.

ANNUITIES: These are protected, have some tax advantages without a profit sharing plan, even more with one. Think of them as the reverse of life insurance. They also grow tax sheltered but provide income in a variety of ways while you live. They have been grossly overlooked.

DEFERRED COMPENSATION PLANS: Recently Florida signed into law protection against creditors in specific plans like P.A. or corporate profit sharing plan. But precedent is not established. Don't put all your faith in wet ink. Increased protection and profit may result from using annuities for plan fund investments.

TIMING: Be aware that you must defend your castle *before* you are attacked. Moving assets around thereafter may be considered in anticipation of an adverse judgment and may be disallowed. Even busy people living by priorities must make the time to protect themselves and their loved ones. Do it now!

I've had the advantage of keeping up with these matters since I was the medical consultant to a financial planning firm many years ago. I learned the language; gained my licenses in securities and insurance, and found people with valid answers. I am happy to share a few with you. Again, I must recommend consultation with your own attorney and accountant. Good luck and accept my wish for peace of mind.

Samuel J. Barr, M.D.
Winter Park

Editor's Note: ***The Journal*** *is in the process of reviewing a more lengthy article for future publication concerning the same subject. Forewarned is forearmed.*

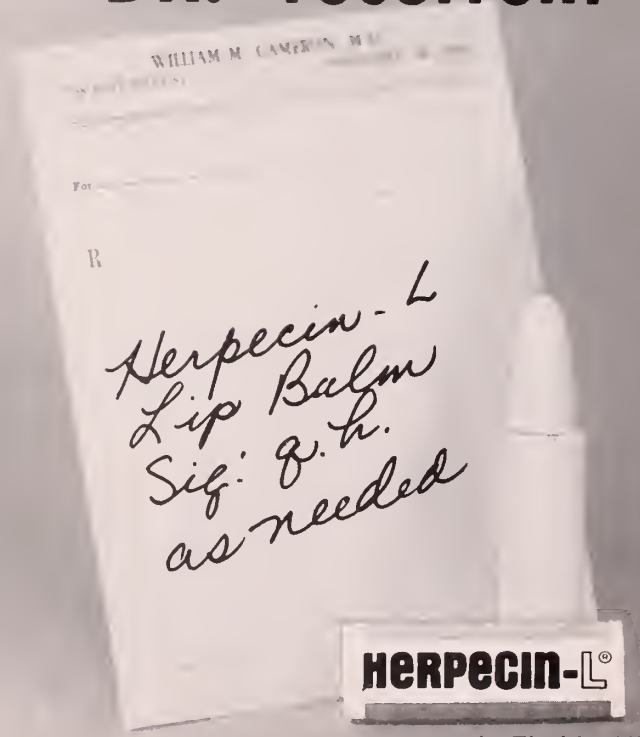
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(See Brief Summary of Prescribing Information on the next page.)

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Transderm-Nitro® nitroglycerin
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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycenn class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycenn dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycenn, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area.
Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone. The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

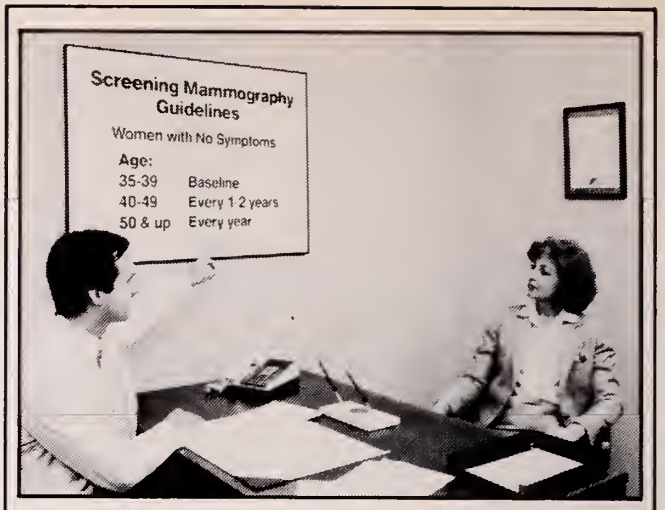
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			*30 Systems...NDC 0083-2025-26
			*100 Systems...NDC 0083-2025-30
5 mg/24 hr	25 mg	10 cm²	30 Systems...NDC 0083-2105-26
			*30 Systems...NDC 0083-2105-26
			*100 Systems...NDC 0083-2105-30
10 mg/24 hr	50 mg	20 cm²	30 Systems...NDC 0083-2110-26
			*30 Systems...NDC 0083-2110-26
			*100 Systems...NDC 0083-2110-30
15 mg/24 hr	75 mg	30 cm²	30 Systems...NDC 0083-2115-26
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
NOVEMBER 1987 Vol. 74, No. 11

Carotid Atherosclerosis and Stroke: A Historical Note

The beginning of our knowledge about carotid atherosclerosis and stroke dates back to the latter half of the 19th century. Savory (1856),[1] Broadbent (1875)[2] and Penzoldt (1881)[3] reported occlusive lesions in extracranial arteries supplying the brain and noted their association with symptoms of cerebral ischemia. In 1905 Chiari[4] described the ulcerated atherosclerotic plaque and found that emboli could originate from carotid sinus plaques and cause strokes.

Despite these early astute observations, there was no clear concept of the carotid artery playing a major role in stroke until the report by Hunt[5] in 1914. Hunt called attention to the importance of extracranial occlusions in cerebral vascular disease. He recognized that both partial and complete occlusions of the innominate and carotid arteries could be responsible for various cerebral syndromes and suggested that extracranial obstructions had been largely overlooked. For the first time, it began to dawn upon those in the medical profession that the cerebral lesion in most stroke patients could be the effect and not the cause.

Because of limitations in the clinical examination of carotid arteries, recognition of carotid atherosclerosis remained mainly retrospective until 1927 when Moniz,[6] a Portuguese neurosurgeon, laid the foundation for modern cerebral angiography. Nine years later, Sjoqvist[7] reported the first case of carotid thrombosis demonstrated by arteriography. In 1951 and 1954, Fisher[8,9] reemphasized the relationship between cervical carotid disease and cerebral vascular insufficiency. He defined the basic pathologic lesion as atherosclerosis and described several ischemic syndromes associated with partial and complete occlusive disease. Fisher prophesied: "It is even conceivable that some day vascular surgery will find a way to bypass the occluded portion of the artery during the period of ominous fleeting symptoms. Anastomosis of the external carotid artery or one of its branches with the internal carotid artery above the area of narrowing should be feasible."

On October 20, 1951, Carrea, Molins and Murphy[10] in Buenos Aires performed the first carotid reconstruction operation for cerebral vascular insufficiency, an end-to-end anastomosis of the external carotid to internal carotid artery. Subsequently, on August 7, 1953, DeBakey[11] performed the first successful carotid endarterectomy in a patient with a completed stroke caused by total occlusion of the internal carotid artery. Since there was considerable delay in reporting these two cases, the major impetus to carotid surgery is usually attributed to Eastcott, Pickering and Rob who on May 19, 1954, performed a successful resection of the carotid bifurcation followed by end-to-end anastomosis between the common carotid and distal internal carotid arteries. The case was reported in November 1954.[12] In June 1954, the same surgeons successfully performed the first carotid endarterectomy for partial occlusion of the internal carotid artery, the standard operation performed today for stroke prevention.

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Daniel B. Nunn, M.D.
Guest Editor

Noninvasive Testing for Cerebrovascular Disease

John A. Schwartz, M.D., and William M. Blackshear Jr., M.D.

ABSTRACT: This article reviews the commonly available noninvasive tests used to diagnose cerebrovascular disease and defines their role in the identification of the stroke-prone patient. These techniques are classified into those that detect alterations in blood pressure or flow in distal branches of the internal carotid artery resulting from high-grade stenosis or occlusion in the cervical carotid arteries (indirect tests) and those that attempt to define the full extent of pathologic anatomy at the carotid bifurcation (direct tests). Both indirect and direct testing are diagnostic modalities which provide physiologic and anatomic data relevant to clinical decision making. The application of these tests for the various categories of patients usually referred to a vascular laboratory for evaluation is summarized. Although an appreciation of the technical aspects of noninvasive cerebrovascular testing is required, the proper utilization of the various techniques rests on an understanding of the pathophysiology and natural history of carotid arteriosclerosis and cerebral ischemia.

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Cerebrovascular disease accounts for approximately 200,00 deaths each year in this country. In two thirds to three quarters of individuals with ischemic cerebral symptoms, the responsible lesion can be localized to the extracranial carotid arterial system. The predilection for arteriosclerosis to affect the carotid bifurcation is well known. However, it is important to remember when considering carotid arteriosclerosis that a permanent, fixed neurologic deficit may be the first symptom of the disease.

If all asymptomatic patients with carotid disease were to present with transient ischemic attacks (TIA) prior to development of a complete stroke, diligent follow-up until symptoms occur would clearly be the preferred method of management. Unfortunately, stroke without warning occurs in 74% of all patients with cerebral infarction as documented by the Harvard Cooperative Stroke Registry.[1] Although all etiologies of stroke were included in this prospective series, the data concerning large vessel thromboembolism, including the carotid and vertebrobasilar systems, revealed that warning TIAs did not occur in 50% of patients. This finding has been confirmed by other investigations of cerebrovascular disease.[2] Therefore, if surgical or medical therapy of extracranial lesions is reserved until patients develop TIAs, at least half of those with carotid arteriosclerosis may be at risk of suffering a stroke.

Prior to the past ten to 15 years, detection of significant atherosclerotic plaques in the cerebrovascular system had largely relied on manifestation of symptoms and subsequent confirmation of the disease by aortic arch and cerebral angiography. Recent accelerated advances in noninvasive vascular technology have resulted in development of a wide variety of techniques intended to identify arteriosclerotic disease in the carotid arteries. The

Table 1.—Indirect Noninvasive Cerebrovascular Diagnostic Techniques.

Technique	Parameters Measured
Supraorbital Doppler Examination	Collateral flow patterns
Oculoplethysmography (OPG)	Ocular pulse delay
Oculopneumoplethysmography (OPPG)	Ophthalmic artery pressure

purpose of this article is to review the commonly available noninvasive tests and to define their role in the identification of the stroke-prone patient so that intervention might be instituted prior to development of a permanent neurologic deficit. The prudent use of these techniques along with the identification of associated risk factors and a careful clinical evaluation are crucial to any attempt to decrease the significant morbidity and mortality from cerebral infarction.

Noninvasive techniques ● Noninvasive techniques may be classified into those that detect alterations in blood pressure or flow in distal branches of the internal carotid artery (ICA) resulting from high-grade stenosis or occlusion in the cervical carotid arteries (indirect tests) and those that attempt to define the full extent of pathologic anatomy at the carotid bifurcation (direct tests).

Indirect tests

These methods utilize the first major branch of the internal carotid artery, the ophthalmic artery, to indirectly evaluate internal carotid artery pressure and flow. Usually listed in the general category of indirect tests are supraorbital Doppler examination (SOD),[3,4] oculoplethysmography (OPG),[5] and oculopneumoplethysmography (OPPG),[6] (Table 1). A directional Doppler is used in the SOD to identify altered flow patterns in the periorbital branches of the ophthalmic and external carotid (ECA) arteries caused by a marked reduction in intracranial perfusion pressure resulting in collateralization from the ECA. Conversely OPG detects phasic changes in the volume of the eye produced by a delay in ocular filling related to reductions in pulsatile blood flow. OPPG relies upon measurement of ophthalmic artery pressure, comparing the two eyes to detect unilateral lesions and comparing ophthalmic artery pressure to systemic pressure for patients with bilateral disease.

Since each of these methods depends on hemodynamic changes reflected in sites remote from the carotid bifurcation, they are theoretically only capable of identifying diameter stenoses of more than 50% (75% reduction in cross-sectional area) or total occlusions, which are lesions that can reduce distal pressure and flow. However, they have been shown to be much more accurate for lesions in the 75% to 100% stenosis range and relatively insensitive to moderate levels of disease. Importantly, bilateral lesions are often quite difficult to detect particularly with OPG and OPPG.

Table 2.—Direct Noninvasive Cerebrovascular Diagnostic Techniques.

Technique	Parameters Measured
Carotid Phonoangiography	Bruit intensity, location, and duration
Doppler Imaging (continuous wave and pulsed)	Flow signal mapping and velocity analysis
Real-time B-mode High Resolution Ultrasound Imaging	Arterial wall anatomy and plaque morphology
Duplex Scanning (B-mode ultrasound and Doppler)	Arterial wall anatomy, plaque morphology, and velocity analysis

We have performed detailed evaluations of these tests[7-9] and others have published collected reviews.[10] In general, indirect tests cannot differentiate between complete occlusion and severe disease or between minimal disease and no disease. The accuracy of any noninvasive test is best defined in terms of its sensitivity (ability to detect the presence of the disease) and specificity (ability to recognize the absence of disease). These terms are independent of the relative number of true positives and true negatives in the total population under study and, consequently, are more meaningful than figures concerning overall accuracy. In this light, the indirect tests are limited by a relatively high specificity but only a moderate sensitivity. A normal indirect test does not rule out the presence of carotid artery stenosis, although one can be reasonably confident that a unilateral occlusion is not present. When compared to the direct tests, their utility as the sole method of evaluation is limited in most circumstances.[8,11,12]

Direct tests

The direct tests focus on detecting changes in the cervical portion of the carotid artery and its bifurcation where the majority of lesions occur (Table 2). One of the first noninvasive cerebrovascular techniques was carotid phonoagniography (CPA) which was developed in order to improve the objective evaluation of cervical bruits.[13] Although the specificity of CPA is usually adequate, its sensitivity is poor. Audio frequency analysis[14] was thought to afford a more accurate assessment of the severity of the lesion; however, it suffers from the same disadvantages as CPA in that it is only applicable to patients with bruits and it is not always possible to detect whether the bruit is due to a lesion in the external or internal carotid.

Recent improvements in ultrasound technology, signal processing, and display have resulted in develop-

ment of the currently employed direct techniques: Doppler carotid imaging, real-time B-mode ultrasonic imaging, and duplex scanning.

Several continuous-wave (CW)[15] and pulsed-Doppler[16] flow mapping systems are available for imaging the cervical carotid. All are similar in that they employ a position-sensing device coupled with a Doppler flow velocity detector to produce a two dimensional image or map of the carotid bifurcation. With the exception of complete occlusion, these images are not diagnostic but, rather, they serve to define the anatomy of the vessels and permit the examiner to interrogate Doppler flow signals along their course. These signals are then subjected to real-time spectrum analysis with the use of multiple filters or fast-Fourier transform methods.[17]

All of the useful diagnostic features of the Doppler signal are contained in the time-varying frequency-amplitude spectrum which is presented in an audio or, more accurately, a visual format. We have evaluated pulsed Doppler frequency analysis and have compared it to both direct pressure measurements across ICA stenoses at the time of surgery and angiography. These studies document objective criteria which provide physiologic information relative to flow velocity that is complimentary to the anatomic data provided by angiography.[18,19] A peak frequency of 6.5 kilohertz (kHz) appears to accurately identify lesions with the potential to reduce distal pressure.

Stenoses affect the Doppler spectrum in several ways. A significant luminal narrowing produces an increase in flow velocity which correspondingly elevates the Doppler frequency. Even minor stenoses generate flow disturbances which are reflected in the Doppler signal as spectral broadening. The spectrum of the Doppler signal also depends on the size of the sample volume, that is, the volume contributing to the signal at any one time. A narrow sound beam which interrogates only a portion of the vessel lumen will generate a different spectrum than a sound beam that is wide enough to encompass the entire vessel. When attempting to diagnose turbulence or disturbed flow through spectral broadening, which is seen in areas of minor stenoses, a pulsed Doppler with its limited sample volume will provide a clearer spectrum with less broadening than an CW device, thus improving sensitivity in detecting minor degrees of stenosis. Disease is then diagnosed and quantified through increased frequency (pitch) in the stenotic zone during systole and diastole and by the presence of poststenotic turbulence as indicated by a broadened spectrum (Fig. 1). Occlusion is determined by absence of Doppler signals. Rarely, a patent ICA will be misdiagnosed as occluded in the presence of an extremely tight stenosis with markedly reduced distal flow velocity which falls below the threshold for detecting Doppler shifts. Vessel wall calcification which does not allow transmission of the Doppler beam to the vessel lumen occasionly presents a problem in quantifying disease.[20]

Doppler imaging allows a high level of diagnostic accuracy in identifying all degress of stenotic lesions of the internal carotid artery which represents a considerable advance over indirect tests. However, the techniques are much more examiner-dependent when compared with indirect studies and the technologist requires a longer period to become proficient with their use. The sensitivity of these techniques, particularly the pulsed Doppler imager, is acceptable in detecting nonstenotic, ulcerative plaque although difficulties are sometimes encountered in obtaining studies on patients with tortuous vessels, vessel wall calcification, or high bifurcations.

Although Doppler imaging techniques evaluate the carotid artery directly, they are physiologic studies and the image obtained is based on flow. Real-time B-mode ultrasonic imaging allows visualization of the structural detail of the vessel wall and arteriosclerotic plaque. Structures are visualized by sound-wave reflection from interfaces of tissue with different acoustic impedances, thus providing anatomic detail. Findings with this technique range from excellent correlation with contrast angiography to results which vary depending on the grade of disease present. Opinions differ regarding how the technical quality of the scan affects test accuracy and whether a totally occluded artery can be reliably diagnosed. However most studies have shown a consistent relationship — the better the quality of the scan, the higher its predictive value.[21] In summary, B-mode ultrasonic scanning of the carotid bifurcation does appear to define plaque morphology well but has some limitations with regard to detection of soft fatty plaque and ICA occlusions since the acoustic reflectivity of fresh thrombus is similar to that of flowing blood.

The combination of a high-resolution B-mode ultrasound imaging system with a pulsed Doppler detector, the duplex scan, permits direct examination of the arterial wall and associated plaque along with

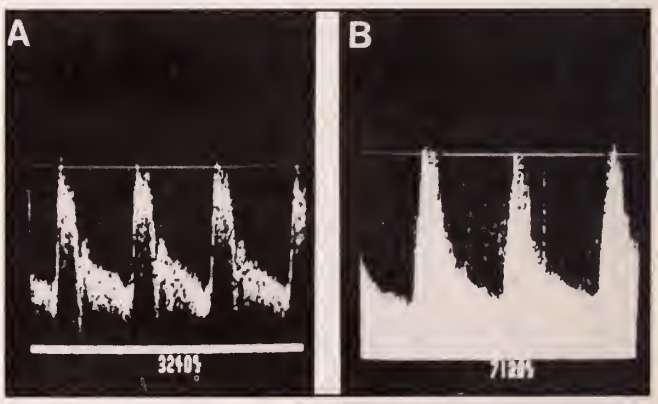


Fig. 1.—Illustrated here are the Doppler spectral profiles from (A) a normal internal carotid artery (scale 0 — 5 kHz) and (B) a carotid artery with a high-grade, flow limiting stenosis (scale 0 — 10 kHz). Note the differences in peak frequency and the spectral broadening (opacification of the "window" under the frequency profile) associated with poststenotic turbulence in the diseased vessel.

frequency analysis of the velocity waveforms. The addition of the Doppler improves accuracy for assessment of stenosis and may detect lesions in areas not accessible to direct B-mode examination. The ultrasound image not only shows the vessel under examination in real time but allows the examiner to determine both the angle of incidence and location of the sample volume of the Doppler beam so that the velocity calculations may be performed in specific sites in the vessel. Interpretation of the Doppler spectral changes is similar to Doppler flow imaging techniques. Another significant function of the high-resolution ultrasound image is the ability to examine the surface characteristics of the atherosclerotic plaque since gross plaque surface irregularity or frank ulceration is thought to be a common source of emboli that result in transient cerebral ischemia or stroke. Intraplaque hemorrhage, which is often seen in newly symptomatic plaques, may also be identified by the ultrasound characteristics of the lesion.[22-24]

The assessment of carotid artery disease by duplex scanning depends on the interpretation of spectral changes in the center stream velocity patterns recorded from specific sites along the carotid arteries. Studies have shown acceptable accuracy for predicting and characterizing bifurcation disease. Distinction can be made between high-grade stenoses and occlusions, as well as the identification of many plaques which are not large enough to affect intracranial hemodynamics. In general, the specificity (ability to recognize normal arteries) is approximately 80% to 90% and the sensitivity of the method in identifying disease is 90% to 99%. Through all grades of disease from normal to total occlusion, the accuracy is between 80% and 90% when compared to angiography.[12,17,25] Moreover, recent studies have shown that the accuracy of duplex scanning was markedly superior to arteriography in detecting intimal surface abnormalities and plaque ulceration.[24,26]

Clinical application ● The proper utilization of the various available techniques rests on an understanding of the pathophysiology and natural history of carotid arteriosclerosis and cerebral ischemia. At present, it appears that both indirect and direct testing have application in the vascular laboratory for the noninvasive evaulation of cerebrovascular disease. The use of the two types of tests may be complimentary, or it may improve diagnostic accuracy in certain clinical circumstances. In general the following guidelines should be considered. Tests should be used which have been shown to have a high sensitivity and specificity in one's own laboratory. The minimum number of tests should be used in combination. When using combined techniques the methods should always assess different parameters. The appropriate use of indirect and direct tests for the various categories of patients which one may see in the laboratory is summarized in the following section.

Patient categories

Patients with typical TIA (monocular blindness or hemispheric attacks) may be suffering from emboli from an ICA stenosis of any degree or from flow reduction distal to a high-grade stenosis or occlusion. They may be appropriately evaluated initially by arteriography or by direct tests, both of which have the ability to detect all degrees of carotid disease. If arteriography is normal, a B-mode or duplex scan should be performed to search for small ulcerating plaques. This approach is also applicable to evaluation of a patient with a completed stroke.

Direct tests with their high sensitivity should be preferentially utilized in patients at increased risk for arteriography such as those with an acute stroke or renal failure. Accurate identification of carotid disease helps to establish a definitive diagnosis and plan a course of clinical management.

Patients with nonhemispheric symptoms of cerebral hypoperfusion such as vertigo, syncope, drop attacks, diplopia, bilateral visual disturbances, confusion, or bilateral sensory-motor symptoms present a difficult diagnostic problem. It is unlikely that these symptoms are the result of emboli from the carotid bifurcation and many of these patients will have carotid and vertebrobasilar lesions. Under some circumstances these patients may well be evaluated by indirect tests since the detection of cerebral flow reduction is all that is necessary although direct tests are still the most accurate method of evaluation. Direct tests may help assess the adequacy of collateralization in those with significant stenosis of the carotid arteries detected by indirect studies, thus sparing the majority the need for angiography. The ability of pulsed Doppler techniques to identify lesions with the potential to reduce distal pressure (peak frequency $\geqslant 6.5$ kHz) is a clear aid in clinical decision making both for patients in this category and for asymptomatic patients.

Patients with asymptomatic cervical bruits should be evaluated by a direct technique. Indirect tests are not advised due to their high false-negative rate and limitation in detecting bilateral disease. As noted previously direct studies may select those patients with high-grade ICA stenoses at risk for the development of symptoms so that appropriate angiography and therapy can be planned. Although this approach to the management of carotid disease is based on clinical data, its validity should continue to be confirmed by prospective, controlled, randomized studies. If direct tests reveal completely normal carotid arteries, further evaluation is unnecessary; however, if lesions of mild to moderate severity are identified, these individuals should be reevaluated at yearly intervals to detect disease progression.[25]

Following carotid endarterectomy, both indirect and direct testing may be performed. Both types of tests may serve as a baseline and can be repeated in the postoperative period. Immediately after operation

indirect tests are preferred because of their simplicity. Furthermore, neck wounds may not allow adequate direct testing. Late follow-up using noninvasive techniques helps detect recurrent stenosis.

Significance of positive noninvasive testing

Although the major purpose of noninvasive testing is to improve selection of patients for invasive cerebral angiography, recent studies have suggested that they have value in assessing asymptomatic carotid disease. There are now four reports of the natural history of asymptomatic stenosis appraised by these techniques.

Kartchner and McRae[27] studied 1,278 patients with asymptomatic bruits examined by OPG and CPA. In 775 patients with negative noninvasive tests, the incidence of TIA and stroke in the observation period (average follow-up two years) was 2.1% and 1.9%, respectively. Of the 143 patients determined to have significant carotid disease by abnormal OPG, 4.9% developed TIAs and 11.9% developed stroke.

Busittil et al[28] evaluated 73 patients with asymptomatic bruits using OPPG and observed their clinical course over a mean follow-up period of 30.6 months. Forty-five patients were found to have hemodynamically significant stenosis and, of those, 13 (28.9%) developed TIAs and three (6.6%) suffered a stroke. Of the 28 patients with negative tests there were no strokes and TIAs developed in only two patients (7.1%).

Roederer et al[25] published the results of a detailed prospective study of 167 patients with asymptomatic cervical bruits serially followed by duplex scanning. During the 30 month period of follow-up, ten patients (6.0%) became symptomatic, six with TIAs and four with stroke. The development of symptoms was accompanied by objective evidence of disease progression in eight of these patients. In evaluating all categories of disease, 60% of the arteries were found to have evidence of disease progression. The mean annual rate of progression to a >50% stenosis was 8.0%. The importance of this particular study was that it emphasized that neurologic symptoms were rare in the absence of a high-grade stenosis ($\geq$80%) and that age, diabetes mellitus, and cigarette smoking were associated with more rapid progression of disease.

Sumner and his colleagues[29] have recently reported a five-year follow up of 294 unoperated and 81 operated patients evaluated by pulsed Doppler imaging technique. They noted that the incidence of stroke in patients with carotid artery disease who were asymptomatic or had vague nonhemispheric symptoms was strongly influenced by age and hypertension. Noninvasive detection of hemodynamically significant stenosis ($\geq$50% diameter reduction) initially defined a subset who were at increased risk for stroke, this group exhibited a 15% incidence at two years compared to a 3.0% incidence in patients with a 1.0%-49% stenosis. Interestingly, the risk associated with a less severe stenosis increased substantially with time. Elderly patients who were hypertensive with a $\geq$50% stenosis had a very high incidence of stroke, TIA, and fatal cardiac events over a five year period.

Sandok has defined the criteria for an ideal noninvasive test: safety, economy, ability to detect all degrees of carotid disease, and ability to assess the intracranial flow dynamics.[30] Both indirect and direct noninvasive testing are diagnostic modalities which are of value in assessing carotid artery disease, although direct studies appear to best fit Sandok's criteria because of their ability to detect normal or minimally stenosed vessels. Each provides physiologic data which is an important adjunct in clinical decision making. Proper application of these techniques is based on a thorough understanding of the natural history of carotid artery disease accompanied by correlation with the patient's clinical presentation.

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Radiologic Diagnosis of Cerebrovascular Disease

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ABSTRACT: The imaging of cerebrovascular disease requires careful thought in order to maximize the data obtained while minimizing risks, especially for invasive procedures. Since many diseases can present with symptoms similar to atherosclerotic disease, it is necessary to utilize enough neuroradiologic imaging procedures to ensure that the appropriate diagnosis is made. This report surveys the several neurovascular imaging procedures including conventional cerebral angiography, arterial and venous digital vascular imaging angiography, computed tomography, xenon-enhanced CT, and magnetic resonance imaging (MRI). The risks and benefits of these procedures are analyzed and their strengths and weaknesses emphasized in the context of imaging cerebrovascular disease.

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Carotid vascular disease can be subdivided into two general categories; namely, disease related to atherosclerotic/arteriosclerotic processes and to nonatherosclerotic abnormalities. This is convenient but not practical prior to definitive tissue diagnosis. From an imaging point of view, many possibilities enter into differential diagnosis prior to completed pathologic diagnosis (Table 1). This becomes important when comparing the effectiveness of various imaging procedures. It is not sufficient to state whether venous digital angiography is better or worse than Doppler/ultrasound carotid studies. Rather, a determination of the potential risk/benefit relationship must be utilized based on the presenting clinical symptom complex. We (attending physician, referral physician, and imaging radiologist) share in the responsibility of obtaining an accurate diagnosis in a reasonable period of time, and, therefore, must jointly derive an imaging algorithm which provides accurate diagnostic information to allow appropriate therapeutic measures to proceed. Two general types of diagnostic errors can be made. Type I: When imaging tests are negative what is the likelihood of having missed a significant disease process? (Fig. 1). Type II: Having discovered an abnormality, what is the likelihood that this disease process accounts for the patient's symptom complex? These considerations are especially important when invasive testing is being considered.

Cerebrovascular anatomy is accurately evaluated with intravascular contrast media using either digitized image methods or conventional angiography with analog subtraction techniques employed. Conventional transarterial angiography continues to be the standard against which other studies are measured. The remainder of this report will deal with the risk/benefit relationship of a variety of neurodiagnostic

Table 1.—Differential Considerations for Cerebrovascular Disease.

Genetic Defects:	Marfans, Ehlers-Danlos, pseudoxanthom elasticum aneurysm, vascular malformations, fibromuscular dysplasia, arteriomegaly, Moya-Moya, AVM.
Infectious Arteritis:	tuberculosis, aspergillosis, cryptococcosis, pyogenic arteritis, syphilitic arteritis, septic embolism, herpetic angiopathy.
Noninfectious Arteritis:	congophilic angiopathy, periarteritis and SLE, temporal arteritis, Takayasus disease, hypersensitivity arteritis, thrombotic thrombocytopenia (TTP).
Blood Dyscrasia with Vascular Disease:	polycythemia vera, hemoglobinopathy, severe anemia.
Metabolic Abnormalities:	atherosclerosis, diabetes with accelerated atherosclerosis, homocystinuria, familial hypercholesteremia.
Cardiac Disease with Cerebrovascular Complications:	arrhythmia, marantic endocarditis, valve disease, mural thrombus.
Traumatic Cerebrovascular Disease:	dissection- extracranial or intracranial, pseudoaneurysm formation.
Arteriosclerosis:	fusiform aneuyrsms, arteriomegaly, ischemic demyelination, Monckeberg's sclerosis.
Hypertension and Related Vascular Disease.	

modalities commonly employed in the evaluation of patients with apparent cerebrovascular symptoms.

Conventional cutfilm cerebral angiography • Recent developments in conventional angiography have come in the form of improved catheters, guidewires and contrast media. Catheters can be treated with a benzalconium-heparin solution to reduce clot formation on the external surface. The transarterial catheterization procedure is relatively standard and has not changed appreciably over several years. The risk of the procedure is still, in large measure, operator dependent. However, the use of catheters 5 French (FR.) or smaller has reduced the risk of direct arterial trauma both at the puncture site and within catheterized vessels. Only occasionally is the use of catheters 6 FR. or larger necessary. The development of variable stiffness guidewires has allowed for easier catheter maneuvering in tortuous vessels. Arterial DVI has enabled the angiographer to achieve excellent opacification of cervical and intracranial circulations with catheterization of only the proximal brachiocephalic vessels. These advances have substantially reduced the time required for complete cerebral angiography to less than one hour in most patients.

Such technical advances combined with wider availability of radiologists with adequate training in techniques and interpretations of neurodiagnostic studies have substantially reduced the risk of transarterial catheterization and cerebral angiography. The incidence of neurologic complications (including hemiparesis, aphasia, blindness, and amnesia) in a variety of studies range between 0 and 0.3%. The risk of carotid/vertebral angiography reported by institutions where the studies are performed by neuroradiologists has a combined complication rate of less than 0.5% of cases. Most of these are related to puncture site hematoma and discomfort. Serious complications (stroke, intravascular occlusion) occur in less than 0.1% of cases. Major contrast hypersensitivity including laryngeal edema, vascular collapse, cardiac arrhythmia and bronchospasm occur in some form in fewer than 0.1%. Anaphylaxis, shock and death occur much less commonly. However, if a previous idiosyncratic or anaphylactoid hypersensitivity reaction is known, the risk of further reactions following repeat exposure to contrast media is reported to be as high as 30%. Therefore it is essential that preangiographic premedication is given to lessen the risk.

It should be noted that the risk of neurologic deficit increases between 0.3% to 0.6% when cerebral angiography is performed in patients with atherosclerotic cerebral vascular disease. The risk of replicating a preangiographic symptom is between 9-10% in patients with frequent transient ischemic attacks or stroke in a subacute phase of resolution. Patients with stroke in an acute stage of evolution should probably undergo angiography only if a diagnosis other than atherosclerotic thrombosis is being considered (especially if it determines medical management decisions) or if acute embolectomy is being considered as part of a surgical approach to the problem. Certain groups have higher complication rates including patients with hypercoagulable states, sickle cell disease, homocystinuria, myeloma, and pheochromocytoma. In these patients particular effort should be made to maintain adequate hydration during and following the angiogram. Conventional angiography requires mechanical processing to acquire subtracted films. However, subtraction of every cerebral angiogram is essential to fully appreciate the data (Fig. 2). Critical error in interpretation can occur when subtraction techniques are not used. The



Fig. 1a

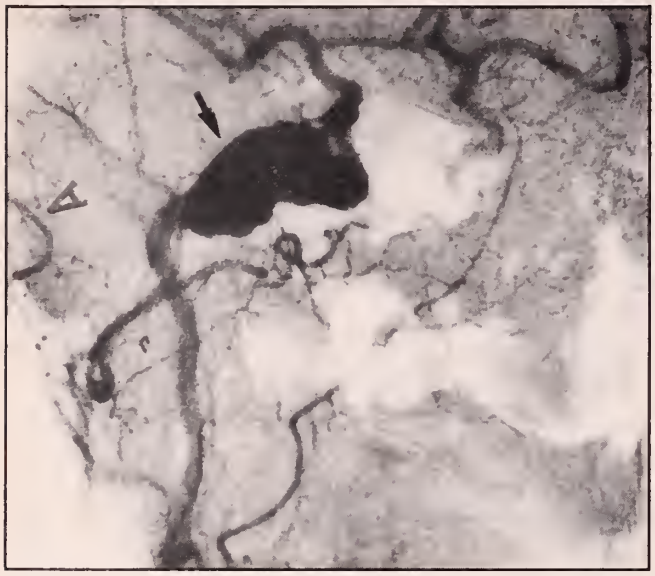


Fig. 1b

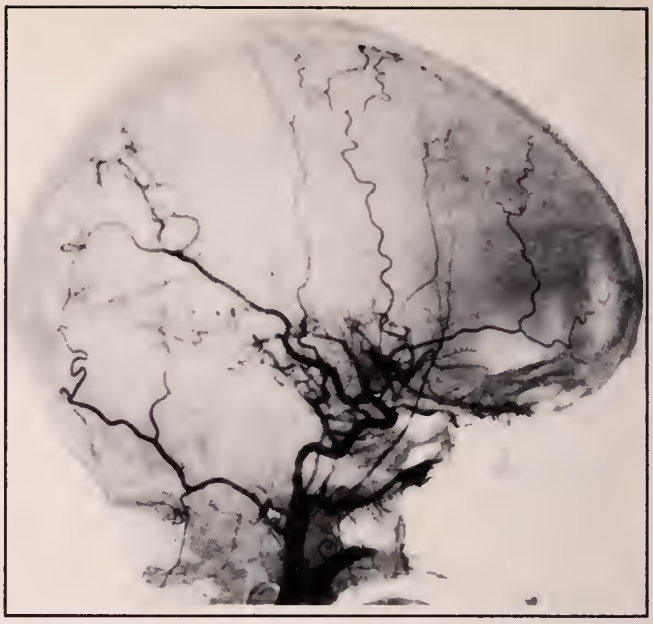


Fig. 1c

Fig. 1.—Limitation of noninvasive testing. These three cases are examples of patients presenting with cerebral oligemic symptoms in an age group where atherosclerosis could be occurring. In each case the pathology is located in either the high cervical carotid (Fig. 1A—focal atherosclerotic stenosis), the intrapetrous carotid segment (Fig. 1B—intrapetrous fusiform arteriosclerotic aneurysm), or basilar intracerebral vessels (Fig. 1C—adult form of Moya-Moya angiopathy). These cases illustrate the need to proceed beyond ultrasonic doppler exams when obvious disease is not evident in the cervical carotid bifurcation. They also illustrate the range of cerebrovascular pathology which can occur.

referring physician can expect that subtraction techniques are utilized routinely when evaluating any carotid/vertebral angiogram in the posterior fossa, the high cervical carotid, and base of the skull regions.

Digital vascular imaging (DVI) • Initial enthusiasm for digital image processing (DVI) using intravenous contrast media injection has dwindled in all quarters. Difficulties arise because of improper registration of the mask image with the vascular image caused by motion of the patient, by respiratory motion, and even by vessel pulsation occurring during the normal cardiac cycle. The latter occurs, especially, when there is calcification in the vessel wall. Contrast density is also dependent on cardiac output. Therefore, patients with low cardiac output often have venous digital angiography of very limited quality. What then has happened to digital angiography? As is often the case, further refinement of this technology has occurred. Registration (the superimposition of the mask and acquired images) has been substantially improved which allows for correcting in various planes. Likewise, the line-pair resolving capacity of the imaging chain has improved with 512×512 and 1024×1024 image matrices widely available. Flow analysis and time-density curves can be used to determine the rate and order of vessel filling as well as determining the cross-sectional diameter of a vessel. The addition of a color mode provides information that delineates rate and order of filling of vessels which is useful in the evaluation of vascular malformation and collateral circulation in ischemic disease.

The current use of "venous" digital vascular imaging at the University of Florida Medical Center



Fig. 2a



Fig. 2b

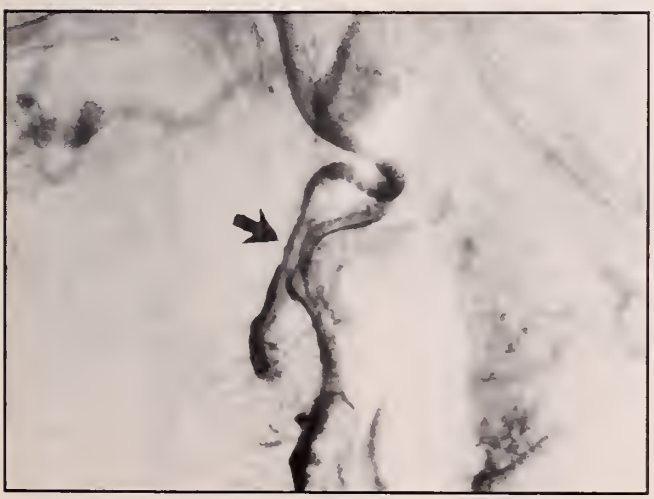


Fig. 2c

Fig. 2.—Value of subtraction techniques in conventional angiography. Standard analog subtraction techniques have been available for conventional cutfilm angiography for many years. Although its use requires patience and attention to detail, subtraction techniques are essential to the discovery of all the pathologic features of the disease process. In this example the unsubtracted angiogram (Fig. 2a) demonstrates an internal carotid occlusion and small ulcerative lesions. The subtracted film of the same image (Fig. 2b) shows opacification of the proximal internal carotid artery (arrow). This pouch could be a source of continued emboli. However, in subsequent films (Fig. 2c) in the same angiographic exam there is delayed filling of a collapsed internal carotid artery (arrow). Delayed filming sequences are essential whenever apparent occlusion exists in order to diagnose the circumstance of a focal high grade proximal stenosis with collapse but otherwise normal carotid artery.

falls into several select categories, but in essence it is used sparingly. Current use includes evaluation of cerebral blood flow for brain death determination, exclusion of intrasellar aneurysms in patients undergoing transsphenoidal resections of pituitary masses, screening prior to interventional procedures especially in children (i.e. vein of Galen aneurysm). Venous DVI is not generally used in the preoperative evaluation of carotid or vertebrobasilar atherosclerotic vascular disease. It is occasionally useful in a postoperative state (especially on an outpatient basis) to evaluate for neointimal fibroplasia and recurrent lumenal stenosis following carotid endarterectomy.

On the other hand, arterial digital vascular imaging (arterial-DVI) has become an important component of all angiographic imaging procedures. It has several advantages over conventional angiography (Fig. 3). The process requires substantially less contrast volume per injection and less contrast concentration. It is particularly useful when evaluating the origins of the brachiocephalic vessels during thoracic arch angiography and vessels more fragile and prone to spasm such as the external carotid and vertebral arteries. Transient tachycardia and hypotension occur during thoracic arch angiography when high volume (22-25ml/sec x 2 sec) high iodine concentration (76%) ionic contrast media injections are employed. These physiologic changes can contribute to neurologic complications associated with arch aortography even in the absence of catheter induced embolism. Angiography performed using arterial DVI, smaller volumes of diluted contrast and catheters of 4-5 FR. in size are associated with fewer physiologic vascular changes. Furthermore, arch angiography is employed (in our institution) only when selective carotid-vertebral studies fail to identify structural abnormalities to account for clinical symptoms. These advantages of arterial DVI have led to its use in outpatient angiography. Such use requires the availability of a short-term observation area and is most applicable when patients reside in the immediate area.



Fig. 3a



Fig. 3b

Fig. 3.—Strengths of digital vascular imaging (DVI). These cases illustrate two of the main uses for arterial DVI. The first (Fig. 3a) demonstrates the presence of a small hemangiomatous lesion in the upper cervical spinal dura. It presented as a subarachnoid hemorrhage. Conventional angiography demonstrated a suspicion of abnormality in this region. However, the capillary matrix of the mass was evident only by DVI. The second example (Fig. 3b) illustrates the use of DVI in the diagnosis of superior sagittal sinus thrombosis (open arrow). Prominent parasagittal sinus collateral venous (solid arrow) drainage is identified adjacent to the thrombosed superior sagittal sinus. A segment of the left transverse sinus is also occluded (double arrow).

Arterial DVI has an additional advantage of imaging the capillary bed of the brain. This has special relevance when evaluating nonatherosclerotic forms of vascular disease. Demonstration of luxury perfusion helps localize areas of small vessel arteriopathy as can occur in inflammatory vasculitis (SLE, giant cell arteritis, herpetic vasculitis). It is also useful in the diagnosis of postirradiation vasculopathy.

The spatial resolution of arterial DVI remains less than that obtained by conventional angiography (Fig. 4). Subtle ulcerations, easily identified on cutfilm studies as the contrast column clears leaving only endothelial coating, may not be obvious by arterial DVI. Likewise, soft intralumenal clot (Fig. 5) is likely to be less evident by DVI than by cutfilm. Another shortcoming of DVI concerns the identification of small intracranial aneurysms. Overlapping of vessels creates a summation density with DVI and, thus, clear separation of vessels can be difficult and aneurysms may be simulated or obscured. This is also true for dissecting aneurysms of the carotid artery. Therefore, as a general rule we, at the University of Florida Medical Center, use a combination of both cutfilm and arterial DVI when imaging the ipsilateral side of symptoms and often screen other asymptomatic vascular territories with only arterial DVI. In essence, arterial DVI has become a critical adjunct to neuroradiological evaluation. Its strengths occur in imaging tortuous vessels without the need for distal subselective catheter positioning, and in the evaluation of altered cerebral capillary bed circulation, both of which occur commonly in the context of cerebrovascular disease.

Newer contrast agents ● Of special importance in any risk/benefit discussion for invasive neuroradiologic procedures has been the development of new contrast agents. Two general types become available including nonionic agents (iohexal, iopamidal) and a different ionic agent (ioxaglate). The nonionic agents can be used for myelography as well as angiographic procedures. The ioxaglate is mainly for angiography and intravenous use. The rate of patient hypersensitivity to these agents is probably the same for standard agents, since this represents an idiosyncratic response. The direct physiologic effects of the nonionic contrast media, however, are substantially minimized particularly for the nervous system. The physiologic effects of ioxaglate (an ionic agent) are not significantly different than for standard contrast agents, however, it has one very important advantage — it doesn't cause pain when injected intravascularly. Therefore, we employ ioxaglate in children and adolescents undergoing cerebral angiography without anesthesia, and more commonly when selective external carotid injections are being performed, or when the internal carotid artery is occluded leaving only the external carotid circulation.

Nonionic contrast agents have been clearly shown to cause less cerebral toxicity than any other contrast

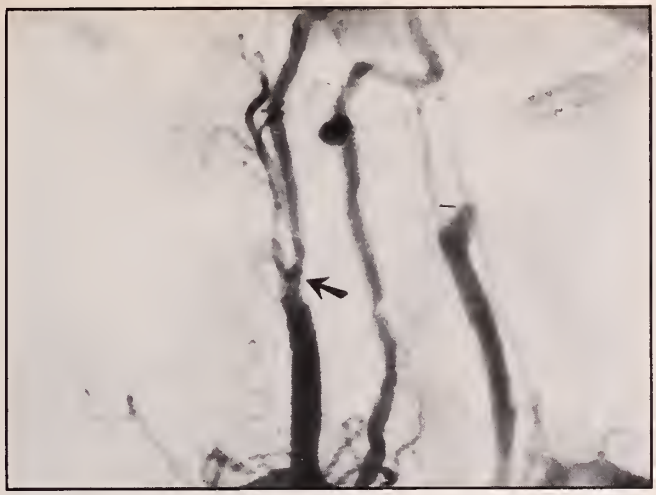


Fig. 4a



Fig. 4b

Fig. 4.—Comparison of cutfilm to digital vascular imaging for thoracic arch aortography. The line pair resolution of cutfilm angiography using small focal spot x-ray tubes is the standard by which angiography is measured. Comparison of conventional angiography (Fig. 4a) with arterial digital studies (Fig. 4b) in the same patient same projection is illustrated. The right carotid stenosis (arrow) is overestimated by the DVI but this is a minor error. The left internal carotid occlusion is imaged on both studies (open arrow). However, the ability of DVI to obtain arch angiography with diluted smaller volume contrast load is a major advantage in avoiding inadvertent procedure related complications. Selective catheterization of the suspicious areas of atherosclerotic disease using DVI, cutfilm, or a combination is essential to adequately evaluate for subtle ulceration, soft intralumenal clot, etc.



Fig. 5

Fig. 5.—Diagnosis of soft intralumenal clot. The diagnosis of soft intralumenal clot can be difficult since it is obscured by the density of the contrast column. This entity (arrow) in our experience has been best seen by conventional cutfilm angiography.

media. Therefore, they are already widely utilized for myelography and angiography. It is presumed that nonionic contrast will reduce the angiographic incidence of seizure and neurologic deficits which may occur during cerebrovascular angiography particularly in patients that have altered blood-brain barrier. This situation occurs in patients with subarachnoid hemorrhage, trauma, some neoplasms, and stroke in evolution. It should be noted that the nonionic contrast media does not prevent thrombus formation within the catheter as the ionic agents do. Therefore, immediate flushing with heparinized saline to remove the nonionic contrast media is necessary to avoid clot formation.

Computed tomography ● Computed tomography (CT) offers a means to evaluate cerebral status without significant risk other than that related to the injection of contrast media. However, it relies on the change in x-ray absorption which is dependent on tissue density. Therefore, in the context of cerebrovascular disease and stroke, CT is somewhat limited when evaluating acute cellular changes often remaining relatively normal until 48-72 hours later when sufficient edema has developed to decrease brain density. High dose contrast infusion can show altered blood-brain barrier earlier providing there has been restoration of blood flow into the ischemic region. However, such effort is seldom of practical value.

CT has the ability to diagnose hemorrhagic infarction, multiinfarction states, and ischemic demyelination. It may be used to exclude an occult mass, an extracerebral fluid collection, or a hemorrhagic infarction. No apparent consensus exists for routine preoperative CT evaluation of every patient displaying symptoms of transient ischemia who undergoes carotid endarterectomy for carotid vascular disease documented by noninvasive testing. As stated previously, CT may help exclude concomitant lesions which can cause transient neurologic symptoms similar to those of atherosclerotic embolic disease, such as giant cavernous aneurysms, arteriosclerotic arteriomegaly, or occult neoplasms. For patients outside the usual range of atherosclerotic vascular disease or those without clear-cut cause and effect relationship between the apparent vascular disease and the symptom complex, preoperative CT or MRI evaluation is essential. MRI has the advantage of imaging regions of vascular compromise earlier than CT, since it can detect cytogenic edema. Therefore, in patients with symptoms suggesting stroke in progress MRI can be utilized as a more effective modality for early detection of ischemic brain disease and cytologic injury than CT. Recent development of gadolinium-DTPA has provided a means of blood-brain barrier evaluation for MRI scanning. Although this may soon become available as an imaging agent, preliminary evaluation in stroke patients at the University of Florida Medical Center failed to show its utility over conventional MRI imaging in this specific clinical context. Suffice it to say that intravenously administered gadolinium-DTPA will provide a means of evaluating blood-brain barrier integrity which will supplement conventional MR imaging.

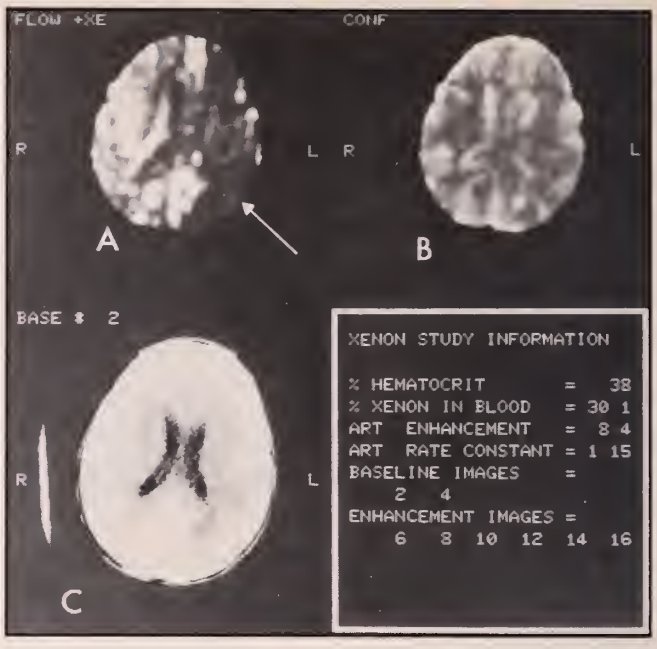


Fig 6.—Xenon cerebral blood flow determination. This method of inhaled xenon combined with CT scanning results in a reasonable estimation of cerebral blood flow. The three images represent the level of section (6C), the confidence limit scan (6B) and the cerebral blood flow image (6A). The confidence limit scan allows the observer to recognize errors in the data as bright streaks. In this case no apparent artifact is present. Therefore, the blood flow data should be accurate within the inherent limits of the technique. In this instance, there is significant oligemia in the left cerebral hemisphere, particularly in the left angular gyrus region (arrow).

Xenon enhanced computed tomography ● Detection of disturbances in cerebral perfusion has presented significant problems because of the complexities of autoregulation and especially dysautoregulation associated with acute and subacute cerebrovascular disease. Multiple probe detection of intravascular radioactive xenon has been utilized to determine cerebral perfusion for years. However, this is a complex and cumbersome method requiring radioactive xenon inhalation or injection and has not ventured from the realm of investigational use. However, the combination of inhaled xenon gas with CT scanning has made evaluation of cerebral perfusion more accessible. Our unit combines a GE 9800 CT scanner with a xenon delivery unit and computer software to generate information concerning regional cerebral blood flow. This has, in our experience, become useful mainly in patients with vasospasm following subarachnoid bleeding, although it has been used in the context of vascular disease and stroke as well. There is insufficient experience to know where and with what degree of reliability this technique determines cerebral blood flow. However, after two years of use there is apparent clinical utility for xenon enhanced CT in the determination of vasospastic cerebral oligemia.

The methodology of this process is based on the ability of inhaled xenon to be rapidly absorbed into the vascular pool and to rapidly cross the blood-brain barrier after which it dissolves in the lipid component of brain tissue which in turn changes the CT density proportional to its concentration. The concentration of the xenon in brain is dependent on regional cerebral perfusion. The data collection includes acquisition of two scan sections prior to inhalation of xenon, followed by acquisition of six scans at the same level after xenon. The difference in CT density between the averaged values of these scans is calculated and extrapolated to ml of blood per 100 grams of tissue per minute. The true accuracy and sensitivity of this test in determining cerebral perfusion is unknown. However, it is apparent that at least relative perfusion can be reasonably well delineated by comparison of the two hemispheres. Abnormal perfusion is based in part on the actual measured perfusion values as well as the relative perfusion (decrease or increase) in the symptomatic region compared to other normal appearing regions (Fig. 6).

Magnetic resonance imaging (MRI) ● Magnetic resonance imaging (MRI or magnetic CT) is currently making a significant impact on neurodiagnosis by providing high quality images of the brain and spinal cord. MRI depends on the interaction between tissue protons and pulsed radiofrequency energy in the presence of a powerful static magnetic field. Protons within various tissues experience a different environment and produce characteristic signal intensity patterns. MRI has the capability to reliably demonstrate major arterial and venous structures in any desired plane of section. The ability to demonstrate vascular anatomy by MRI depends on the presence of flowing blood which alters the MRI signal. Conventional (spin-echo) MRI demonstrates rapidly flowing blood as a signal void with slower blood flow as medium or higher signal intensity. Flowing blood creates a phase shift in the emitted signal which can be further characterized by analyzing the electronic imaginary image equivalent which is always present but not usually reconstructed. Recently, fast imaging techniques using gradient-echo techniques have shown tremendous promise for blood flow characterization and cinemode imaging.

The best evidence for MRI progress in vascular diagnosis is available in the studies of thoracic aortic disease. MRI has become a preferred noninvasive method for assessment of aortic aneuryms and dissections (Fig. 7). In our prospective study of 28 patients with a variety of aortic abnormalities, MRI provided additional information to aortography essential to surgical planning in 28% of cases and altered the surgical approach in one. Aortography was necessary for evaluation of aortic valve disease and coronary artery assessment in 50% of all cases studied. MRI is particularly well suited for diagnosis of aortic dissection by providing clear delineation of the intimal flap and the status of the true and false channels. The brachiocephalic vessels are more difficult to image by MRI due to their smaller size and vessel tortuosity. MRI is not yet as accurate as carotid arteriography or ultrasound for evaluation of disease at the carotid bifurcation but work using surface coils and gradient echo techniques shows promise in this regard. In the brain, MRI can demonstrate giant aneurysms in a manner superior to CT revealing thrombosis and flow through the dilated lumen without contrast enhancement. Occult arteriovenous malformations often exhibit a characteristic ring of hemosiderin, demonstrated as a margin of low signal, around the anomaly.

MRI is also capable of evaluating intracranial vasculature, particularly of the dural venous sinuses. The carotid artery can usually be seen entering the base of the skull. Some difficulty in separating its intrapetrous segment from the dense petrous bone occurs, but the carotid siphon and cavernous carotids are easily assessed. Anterior and middle cerebral arteries are usually seen. The vertebrobasilar system

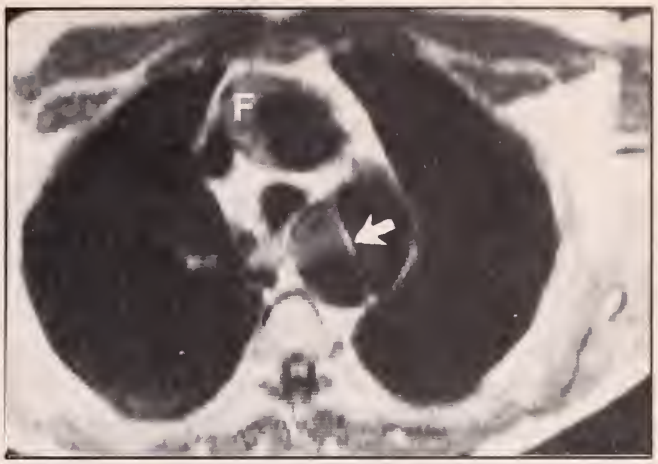


Fig. 7a



Fig. 7b

Fig. 7.—Magnetic resonance imaging (MRI) of aortic dissection. Fig. 7a — Axial section through the thoracic aorta immediately below the level of the arch demonstrates an obvious dissection of the descending aorta with an intimal flap (arrowheads) and double lumen. The dissection extends into the ascending aorta manifest by an increased signal in the false lumen (F). Fig. 7b — This section is through the brachiocephalic vessels. The dissection extends into the innominate artery (arrowhead), but spares the left common carotid artery and the left subclavian artery. This was not well shown on the initial aortogram.

can be identified without bone artifact in the posterior fossa. Dural sinus assessment may prove to be a major advantage of MRI over other techniques. Early reports and our own experience suggest the value of MRI for detecting dural sinus thrombosis. Lack of blood flow in the sinus causes abnormal increased signal intensity whereas normally a signal void is created by the rapidly moving blood. This assessment may be aided by using ECG-gated brain acqusition to assess pulsatile blood flow. MRI is the most sensitive radiologic modality for imaging cerebral infarction. The tissue edema (both cytogenic and vasogenic edema) is easily detected by spin-echo techniques. This occurrence can be seen within 24 hours postin-

farction. However, if transient ischemia occurs in the absence of cellular membrane changes sufficient to cause edema the MRI will not detect an abnormality. In essence, however, MRI has advantages over CT and angiography in the diagnosis of early cerebral infarction.

Overview ● Radiologic neurodiagnostic imaging has ventured into the relatively expensive world of high-tech physics applications, computers, and digitized images. Concurrently, competitive pressures, DRGs, and quality assurance policies necessitate employment of an efficient, least expensive diagnostic algorithm for every patient. Such constraints have forced on the primary physician the dilemma of sorting out issues not only of therapy but of diagnosis. We have been requested to survey radiologic imaging procedures applicable in the evaluation of cerebral vascular disease in order to portray the strengths and weaknesses of such procedures. The complexity of this subject underscores an important concept concerning the role given to the radiologic consultant in the initial planning of a patient's diagnostic testing. Every radiologic imager is expected to be familiar with the range of diagnostic modalities available even when it is not offered in the context of the local community practice. The bottom line is that in vascular imaging every community should expect high quality radiologic imaging service. The radiologist should have the skills and equipment to provide high quality diagnostic information which helps the referring physician judge which patients he can treat in the community and select those patients who would benefit from referral to a tertiary medical center.

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The Neurologist's Perspective of Stroke

Gerald S. Goldberg, M.D.

ABSTRACT: Despite advances in medicine, stroke remains a major crippler and cause of death among Americans. To dramatically reduce the number of strokes, a concentrated effort by physicians, paramedical personnel and patients themselves is necessary. Physicians must stay abreast of recent developments in the field of cerebral vascular disease. They must also encourage patients to reduce risk factors, recognize early warning signs and initiate early medical or surgical treatment. When a serious stroke occurs, nurses and therapists must work diligently and compassionately with the patient. Patients either before or after a stroke must take an active role in their health care and be compliant with physician instructions.

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Despite the declining number of strokes[1-3] cerebrovascular disease continues to be the third leading cause of death and the number one crippler in the United States. Billions of dollars are spent annually to care for stroke patients, while the emotional and economic stress placed on the family unit is immeasurable. Once a completed stroke leaves the patient with severe neurologic deficit, no specific medical or surgical treatment will restore the dead or damaged central nervous system neurons. Therefore, in order to play a significant role in the prevention of this devastating neurologic condition, physicians must be able to identify those asymptomatic patients at high risk for stroke and institute appropriate measures. If a patient presents with a warning sign of stroke, known as a transient ischemic attack (TIA), then immediate evaluation is indicated. Since TIAs have multiple etiologies, many of which are nonsurgical, consultation with a neurologist is warranted so he or she can assist in weighing the risks and benefits of the various diagnostic studies and therapeutic interventions.

Stroke prevention • During the course of everyday medical practice, there are a number of patients who will be recognized through either physical examination or laboratory findings to have an increased risk of stroke. As physicians, it is our duty to appropriately advise and/or treat these patients in order to decrease their chance of having a crippling or fatal stroke.

Hypertension remains the most significant risk factor for stroke. The systolic pressure is more important than the diastolic pressure in predicting atherothrombotic brain infarction, and the incidence of stroke increases proportionately with rising systolic pressure.[3,4] Prompt treatment of hypertension when

first discovered will decrease the incidence of stroke in the hypertensive population. Compliance with taking medications for hypertension, however, is not always good and patients must be constantly encouraged even though they may feel normal. Getting the patient involved in monitoring his blood pressure at home may inspire him to become personally involved in hypertensive management.

Although some believe that hypertension is the only well-documented condition that increases the risk of stroke,[3] other factors may contribute. These include a history of previous stroke or TIAs, atrial fibrillation, cigarette smoking (especially if associated with birth control pills), heart disease, certain blood dyscrasias, hyperlipidemia, alcoholism, and hereditary influences.[4] If any of these known risk factors are identified in asymptomatic patients, appropriate advice and treatment are recommended to further decrease the chance of the patient having a stroke. Obesity per se has not been proven to be definitely involved in increasing the risk of stroke, although it does increase the chance of developing cardiovascular disease.

Asymptomatic carotid bruit ● One of the most controversial aspects of stroke prevention is how to manage patients with asymptomatic carotid bruits. Auscultating the cervical area should be a part of every physical examination. Carotid bruits are the most common cervical bruit and may be present in up to 8% of patients over 45 years of age and in 10% to 20% who are undergoing coronary artery bypass or vascular surgery.[5,6] Plaque at the carotid bifurcation is the cause of most carotid bruits and, although most are from the internal carotid, up to 10% may originate in the external carotid artery. Plaque formation may increase in size over time, and the rate of this increase is in part related to the degree of hypertension.[7] Although a high-pitched, long-duration bruit is most often associated with a tighter stenosis, auscultation alone cannot accurately predict the degree of stenosis.[8] Some patients with significant stenosis may have no bruits at all, or the bruit may decrease and disappear as the artery nears total occlusion.

After an asymptomatic carotid bruit is found, evaluation of other systemic risk factors are in order. Then, a complete, noninvasive evaluation of the carotid arteries should be carried out and, if a hemodynamically significant lesion is found, a conventional cerebral angiogram or arterial digital subtraction angiographic study may be considered in certain cases.

Although there is an increased risk of stroke in patients with asymptomatic carotid bruits, especially in men, the strokes that do occur are often not in the distribution of the affected artery, thus indicating no actual increase in ipsilateral ischemic stroke.[5,6,9] Therefore, one cannot automatically assume that the atheromatous disease causing a bruit is itself responsible for an embolus that caused a stroke. In addition, patients with an asymptomatic carotid bruit, are much more likely to have a TIA than an unheralded cerebral infarction.[10] Despite multiple studies[2,5,11,12] that have evaluated the natural history of the asymptomatic bruit, there is no clear-cut indication at this time that a prophylactic endarterectomy will significantly decrease the risk of stroke. There are some who believe that no patient with an asymptomatic bruit, no matter what the degree of obstruction, should be operated on; however, others consider surgical intervention if the arterial occlusion is greater than 75% to 80%.[13] Before considering surgery, one must weigh the age and general health of the patient. A history of significant hypertension, diabetes, heart disease or peripheral vascular disease should mitigate against any surgical intervention. Also, careful consideration must be given to several other factors including the previous operative record of the local neuro or vascular surgeon, the frequency with which he does the procedure, and the experience of the operating room and general nursing staff. Although the morbidity and mortality may be only 1% to 2% in certain specialized hospital settings, these figures cannot be applied to all hospitals, surgeons or patient populations where rates may be significantly higher. Therefore, if the complication rate of surgery exceeds the chance of stroke, surgery in those instances should be avoided. Finally, after explaining all the various options and risks to the patient and his family, proceeding with surgery on an asymptomatic bruit should not be considered if the patient is in any way hesitant to proceed. Although definitive studies are not yet available, the data suggest prophylactic surgery on asymptomatic patients should be the exception rather than the rule. In general, the most sensible approach, therefore, is to use platelet antiaggregation drugs such as aspirin, do careful follow-up for the occurrence of TIAs, follow the carotid lesion with noninvasive studies, and identify and treat the various cerebrovascular risk factors.

Not only is the asymptomatic bruit an indicator of generalized cerebrovascular disease, it is also an indicator of cardiovascular disease. Several studies[5,6,10] corroborate the fact that in patients with asymptomatic carotid bruits due to stenotic lesions, myocardial infarction occurs more frequently and is more commonly the cause of death than stroke. Therefore, close attention to the cardiovascular status of a patient with an asymptomatic carotid bruit is justified even if the patient is myocardially asymptomatic.

Symptomatology of TIAs ● Since TIAs represent reversible cerebral ischemia and are the major warning signs of a stroke, they require prompt evaluation and aggressive management. Familiarity with the variety of presentations of a TIA is vitally important for any primary care physician. Although by definition the symptoms of TIAs can last up to 24 hours,

most last 15 minutes or less. The duration of the TIA, however, does not have any clear-cut predictive value as to the risk of a subsequent stroke.[4] If the symptoms last longer than 24 hours, they are referred to as a reversible ischemic neurologic deficit (RIND), but these prolonged symptoms have no different prognostic value than a TIA and should be evaluated in the same fashion.

The carotid circulation, also referred to as the anterior circulation, represents the vascular area most often affected in TIAs. Four major groups of symptoms are associated with the carotid circulation disturbances. First, transient unilateral motor deficits may affect the total side or one part of it. Disturbances of the face and arm often occur together and represent problems in the middle cerebral circulation, and localized dysfunction in the hand is not uncommon. When the leg is the primary part affected, this suggests disturbances in the anterior cerebral artery. Next, unilateral sensory disturbances can occur in the same regions as the motor deficits. Frequently, motor and sensory symptoms occur together. Pure motor or sensory symptoms may suggest dysfunction in the internal capsule area and are often due to small vessel disease in the tiny penetrating arteries to this area. Thirdly, visual symptoms, most often due to embolic phenomena, may occur in one of two forms. Amaurosis fugax indicates temporary loss of vision in one eye and is often described as a curtain coming down over the eye. This symptom represents an ischemic event in the retina and is almost always embolic. These tiny emboli may be seen in the arteroles of the eye by funduscopic examination and are referred to as Hollenhorst plaques. Amaurosis fugax may be the most reliable indicator of an impending stroke. Homonomous hemaniopsia, on the other hand, or the ispilateral loss of one half the visual field in each eye originates from the deep temporal or parietal areas of the brain. Patients have difficulty in describing this particular neurologic deficit and often complain of vague decreased vision. Although some patients may actually say they cannot read on the right or left half of a page, most do not; therefore, a high index of suspicion is needed to find this problem. Finally, speech disturbances make up the last set of carotid symptoms. Patients most often complain that they know what they want to say but the words won't come out. This is referred to as an expressive aphasia. The patient may misuse words, have total garbled speech or, in fact, be mute. The latter symptom may sometimes be mistaken for a psychiatric disturbance.

Symptoms in the vertebrobasilar system or posterior circulation are usually quite different than those in the carotid circulation. These include diplopia or double vision, true vertigo, ataxia, dysphasia or trouble swallowing, and dysarthria or slurred speech. This form of speech disturbance is quite different than the type associated with anterior circulation problems. It is primarily a slurring of speech due to poor control of the palatal muscles. Motor and sensory symptoms also occur in the vertebrobasilar system, but they may be either unilateral or bilateral. Numbness around the mouth often indicates a vertebrobasilar disturbance.

Usually one well defined symptom from the carotid circulation and at least two symptoms from the vertebrobasilar system are needed to definitely diagnose a transient ischemic attack. When patients complain of less specific symptoms, often referred to as nonhemispheric symptoms, the symptoms may not represent a true TIA. Included in these groups are syncope, postural lightheadedness, or momentary confusional states. These symptoms most often have a different etiology than TIAs and thus require a different type of work-up and treatment. More often than not, cardiac arrhythmias, orthostatic hypotension, metabolic disturbances or side effects from medication account for most of these ill-defined symptoms. Even if a patient has a carotid bruit, these nonhemispheric symptoms are not an indication that surgery is needed.

Etiology of TIAs ● Once a diagnosis of TIA has been made, the source of the problem must be identified. A careful history and physical examination is the best first step. Embolic phenomena are by far the most common cause of TIAs. Emboli may originate from atherosclerotic disease within the carotid artery, particularly at the carotid bifurcation. It was once thought that "embolic symptomatology" could be differentiated from a nonembolic event, but this is generally not the case.[14] A thorough search for a source of emboli must be made.

Carotid emboli, although the most common source, are not the only source of TIAs. Several cardiac sources exist such as atrial fibrillation and valvular disease, bradycardia, and low cardiac output from congestive heart failure or cardiomyopathies. These conditions rarely produce typical TIA symptoms and are more often responsible for nonhemispheric symptoms. Beta and calcium channel-blockers, autonomic dysfunction such as commonly seen with diabetes and certain electrolyte disturbances or hypoglycemia can occasionally produce TIAs.

Other conditions can produce symptomatology mimicing TIAs. These are quite diverse and can include migraine, aneurysm, arteriovenous malformations, subdural hematomas, various vasculities, multiple sclerosis and epilepsy. The ensuing work-up for a TIA must consider all these possibilities, taking into account the patient's age, associated medical conditions, and general health.

Management of TIAs ● Most TIAs, especially those occurring in persons 50 to 70 years of age, represent a semimedical emergency. Roughly, 25% to 30% of patients with a TIA will have a major stroke at some

point in time. The greatest risk is in the first year (10%) and particularly within the first several months. This will then decrease to about 3% to 8% per year over the next five years.[4] If a patient has a specific cause for the TIA, e.g., known carotid occlusive disease or atrial fibrillation, the risk will be even higher. The actual number of TIAs does not necessarily predict a greater likelihood of stroke.

Of great interest and importance is the fact that over a five-year period, in patients with TIAs, the incidence of both fatal and nonfatal heart disease is greater than that of death from stroke.[4,15] The yearly mortality from cardiac causes of patients with TIAs (6%) exceeds that for patients with angina pectoris and approximates the rate among patients with asymptomatic triple vessel coronary disease.[15-19] Thus, TIAs are like the asymptomatic carotid bruit, a potent warning signal of myocardial disease as well as generalized atherosclerotic disease and must be carefully considered in evaluation and treatment of patients presenting with TIAs. By only evaluating the cerebrovascular system, our treatment will not have an impact on the long-term mortality of patients with TIAs.

In evaluating a patient with a TIA, the first important step is to determine what arterial distribution the TIA occurred in. If the carotid circulation is the area, then a magnetic resonance scan or a CT scan with and without contrast (barring contraindications to the dye) should be one of the first tests. The magnetic resonance scan may be more sensitive in picking up some lesions earlier than CT. These tests will also rule out most of the nonvascular causes that may produce TIA-like symptoms.

Because of the increased sensitivity of neuroimaging techniques, the electroencephalogram has become somewhat less important in determining the etiology of TIA-like symptoms or a stroke. However, since it is a test of cerebral physiology rather than a picture of anatomy, when neurologic deficits persist, electroencephalogram will often show an immediate focal abnormality in a hemispheric insult, whereas scans may be negative for three to five days. Also, if a patient has distinct supratentorial symptoms and a normal EEG, this may suggest a subcortical lesion in the internal capsule, such as from small vessel disease that can be related to diabetes mellitus or hypertension. This may indicate that a carotid lesion is not the etiology of the symptoms.

Noninvasive carotid testing should also be considered soon after a TIA. Duplex scanning, which combines real time ultrasound and Doppler evaluation, can often give a clear-cut picture of the degree of a stenosis as well as the characteristic of the plaque. The greater the skill of the examiner and the greater the number of modalities used for carotid screening, the more accurate will be the information obtained. At times, soft plaque, with or without ulceration and which is more likely to be a source of emboli, can be differentiated from a less dangerous calcified plaque.

After the initial diagnostic testing has been carried out, and it has been determined that the TIA has most likely arisen from carotid artery disease, a decision must be reached as to whether to consider medical management, such as anticoagulation, antiplatelet drugs, and antihypertensive medications, or to proceed with angiography and possibly surgery. Cerebral angiography itself may carry a significant risk for the patient. The dangers of four vessel angiography are higher in patients with TIAs (up to 5%) than in patients undergoing angiography for other reasons (0.1%).[4] Therefore, one should not proceed with angiography unless surgery is a viable option for the patient. If a patient presents with typical hemispheric symptoms, the angiographic evaluation should include good intracranial views. A coexisting lesion in the carotid siphon or in a more distal location may be the actual cause of the TIA rather than a lesion seen in the extracranial portion of the carotid artery. In fact, cerebral angiography shows an appropriate ipsilateral carotid lesion in only 57% to 87% of the cases.[20] Although intravenous digital subtraction angiography is neither sensitive enough to pick up intracranial stenotic lesions nor to differentiate some nearly occluded carotid bifurcation lesions, intraarterial DSA studies may provide this information.

A recent study has indicated that carotid endarterectomy may provide better stroke prevention for symptomatic patients who have either greater than 70% unilateral stenosis or greater than 50% bilateral stenosis, or unilateral occlusion associated with greater than 50% stenosis on the contralateral side.[21] The patient should not have other life-threatening or disabling symptomatic conditions since these increase the risk of surgery even in the best of hands. If the combined risk of angiography and stroke from endarterectomy approaches 3% to 4%, this approximates the short-term risk of stroke from TIA and, therefore, the decision to proceed with surgery must be seriously considered. This is especially true in those hospitals where the risks may be even greater.

If a patient has a TIA with a mild stenosis or small ulcerative plaque but is not considered a candidate for endarterectomy, then intravenous heparinization may be indicated. This should be followed by four to six months of oral anticoagulants, assuming no medical contraindications for anticoagulation. An inappropriate candidate for this particular therapy would be the patient who is unreliable in either taking the medication, in getting medical follow-up or pro-times, or has a history of frequent falls. When anticoagulation is used, pro-times at 1.3 to 1.5 control rather than 2 to 2.5 control, which was the old recommendation, have been shown to be just as effective and will be associated with a lower complication rate.[22] After four to six months the anticoagulant can be withdrawn and antiplatelet drugs

used. Ulcerative carotid lesions have been shown to heal over several months when serial angiographic studies have been performed.

The use of platelet antiaggregation drugs remains controversial. Studies have shown that the use of aspirin on a daily basis will decrease the incidence of cerebral infarction.[23,24] The exact dose of aspirin that exerts the best platelet antiaggregation effect has not been fully resolved. Some studies were carried out using one aspirin (325 mg) per day and others have used up to four aspirin (1300 mg) per day. All have shown a beneficial effect no matter what the dosage.

The use of dipyridamole, however, has been reviewed in a recent article[25] and its efficacy questioned. Information based on the available well-controlled studies indicate that orally administered dipyridamole exerts little, if any, independent antithrombotic action in humans, and that when given along with aspirin contributes little to the antithrombotic action and clinical effectiveness of aspirin alone. Therefore, this study and others[26,27] do not support the widespread use of dipyridamole for stroke prevention.

Despite our best efforts at preventive medicine or medical and surgical treatment, many patients still have completed strokes with significant neurologic deficits. In the completed stroke with dense neurological deficit, surgical intervention is contraindicated. When a stroke occurs, however, the importance of prompt physical, occupational, and speech therapy cannot be underestimated. Some centers begin such therapy when medically feasible on the first or second day of hospital admission. Prolonged bedrest and general inactivity is detrimental. A recent study evaluated factors that affect both short-term and long-term outcome of stroke. Indications for short-term longevity include impaired consciousness, leg weakness, and advanced age; whereas long-term longevity was influenced by low level of activity at the time of hospital discharge, advanced age, male sex, heart disease, and hypertension.[28]

Many aspects of stroke prevention and management continue to be controversial. Certain trends are emerging, however, and physicians must stay on top of current developments in order to provide the best medical care that is tailored to the particular situation that may affect each patient.

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Extracranial Carotid Atherosclerosis: A Frequent Problem for the Primary Care Physician

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ABSTRACT: Thoughts are presented in a question and answer format regarding management of extracranial carotid vascular disease. Data are scanty about the natural history. The literature is confusing. The exact role of medical versus surgical therapy is not as yet defined and will require a large multicenter randomized trial to settle the place of each and the subgroups most benefited.

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Cerebrovascular disease is the third leading cause of death in the United States and results in major disability in many surviving patients. There is a large volume of literature, somewhat conflicting, on the relative merits, risks and benefits of various treatment strategies to prevent a disabling stroke resulting from carotid atherosclerosis. Extensive natural history data are lacking and a large prospective trial of medical versus surgical therapy ultimately may establish the place of endarterectomy versus medical regimens.

In this presentation, we attempt to establish a reasonable and logical position or strategy by answering questions a physician might ask who is responsible for the day-to-day care of patients. Other presentations[1,2] provide background for a current picture of noninvasive testing as well as radiologic procedures useful in evaluation of the problem. Critical appraisal from a neurologic standpoint is also presented,[3] especially the important clinical problem of what is and is not a TIA.

What do pathologic studies of extracranial vascular disease reveal?

Atherosclerosis in most patients represents a generalized disease process recognized by physical symptoms and laboratory findings usually in the area of most notable manifestation. Manifestation in one vascular bed usually indicates others are involved even though clinically asymptomatic. Schwartz and Mitchell[4] in unselected autopsies found the highest incidence of severe atheroma in the carotid sinuses. There was a significant difference in involvement of segments of the carotid arteries. The carotid sinus, for example, was often calcified and ulcerated, whereas the cervical segment rarely showed more than simple fatty streaking. The characteristic lesions in the

terminal internal carotid segment were calcified plaques. There was no consistent difference in atheroma grading between the right and left sides or between the sexes. If, however, men and women were compared on an age basis, more men 35 to 54 and 55 to 74 years than women had severe atheroma. Over age 75, women had a higher incidence. The overall highest incidence of stenosis was in the vertebral arteries and one in four men in this unselected sample had severe vertebral narrowing. The high grade stenosis contrasted sharply with the number of atheroma. The calibre of the vertebral arteries allowed them to be narrowed by the thick localized fibrous plaque, the characteristic lesions found in these vessels. After the vertebrals, the carotid sinuses were the next most common site for stenosis and severe narrowing was found in one in seven men. Severe stenosis in other arterial segments was less common, but occurred in a significant number of innominate, subclavian and common carotid arteries. One of the most striking features of atheroma of the carotid and vertebral systems was its patchy distribution.

A correlation between aortic atheroma and carotid and vertebral stenosis showed approximately twice as much of the aortic area covered with complicated (ulcerated, calcified, or thrombotic) atheroma in men with narrowed vertebral arteries and carotid sinuses as in men with no stenosis in these sites.

Atheromatous ulceration was found in 13 of 93 subjects, 11% of men and 2.5% of women, at some point along the carotid system. Lesions were often multiple and the most common single site was the carotid sinus. None were seen above this level. In the vertebral systems 7.5% of men and 5% of women had such lesions, all in the subclavian arteries. No ulceration of the vertebral arteries per se was found.

There were attempts at correlation with stroke as 27 of the 93 autopsy subjects showed symptoms and signs indicating "cerebral vascular disease" (hemiparesis or brain stem manifestations). It was noted that a significant proportion of those over age 75 with symptoms had no stenosis in any part of the four arterial systems studied suggesting an age-dependent factor not related to state of the neck arteries. The frequency of stroke increases with age even in patients with normal neck arteries. The frequency of narrowing of the neck arteries increases with age, therefore, stroke and narrowing strongly correlate even if the neck artery disease is not causally related to the stroke. Whether stroke was related to neck artery narrowing was not determined by the investigation.

The pathogenesis of atherosclerosis[5,6] suggests that as plaques grow and narrow the lumen they become "complicated," usually defined by gross evidence of ulceration, hemorrhage or thrombosis. Stenosis changes the usual lumen flow causing turbulence that erodes plaques and leads to ulceration and disintegration. The complex plaques are more susceptible to intraplaque hemorrhage, ulceration and luminal thrombosis. Hemorrhage is found more commonly in specimens from patients with TIAs or strokes than from asymptomatic persons. Patients may remain asymptomatic as long as the plaque remains smooth and the endothelium intact, however tight the stenosis. Nevertheless, a tight stenosis seems more likely to result in symptomatic changes and is also frequently associated with degenerative changes within the carotid plaque.

What is the natural history of carotid bifurcation atheroma? Does it progress? Is atherosclerosis reversible?

Javid et al[7] studied change in the angiography appearance of 93 patients who initially had internal carotid stenosis varying to 60% of the lumen. All lesions were followed for at least 12 months with a range of one to nine years and an average of three years. There was no change in appearance of the lesion in 35 of 93 patients. Roughly one third, i.e., 32 of 93, had greater than 25% change, 19 had less than 25% change, and seven had recurrent stenosis or thrombosis. Age, sex, incidence of diabetes, or presence of other vascular lesions did not appear to influence the rate of atheromatous change in the bifurcation. However, hypertension, presence of symptoms, localized carotid bruit, and significant stenosis appeared to predict rapid change. Significant was hypertension; 70% of these patients had carotid artery narrowing greater than 25% per year compared to 37% in whom the lesion did not change significantly. It appears realistic to assume that a hypertensive individual with persistent symptoms, localized bruit, and carotid bifurcation stenosis of greater than 25% is likely to have rapid changes in the atheromatous plaque. At least one third of patients will show no progression over three years of observation, but two thirds will. This study dates from 1970, an era of less enthusiastic efforts in control of hypertension and other risk factors. In the 1986 study by Chambers et al[8] carotid artery disease progressed in 30% to 40% of patients, but sometimes regressed.

Reversibility of atherosclerosis takes one of several forms including marked slowing in the rate of progression, stabilization of the lesion with no seeming progression over time, and an actual reversal process with increase in luminal diameter.

There are sufficient studies[6] of different vascular beds which make a rather positive and convincing argument for reversal of the process of atherosclerosis in some patients as a result of treatment.

Should one diligently examine the neck and other surrounding areas for unusual noises and carefully palpate the carotid vessels as well as examine for evidence of collaterial flow via the external carotid?

The answer is a clear-cut yes, provided one recognizes that the finding has limited usefulness and rather broad clinical implications. Several presentations provide guidelines regarding auscultation technique, length of bruits, presence of palpable vessels, and differential diagnosis of noises in the neck.[9-12] The factors I consider most important in searching for carotid bruits is to have the room quiet, patient relaxed, recumbent with the head supported on a pillow, and holding the breath while I listen carefully over the carotid bifurcation and base of the neck. One must differentiate transmitted noise from the thorax versus a true carotid bruit. A bruit will be louder over the carotid bifurcation and transmitted noise louder at the base of the neck. Once a bruit is detected and determined to arise from the carotid bifurcation, length and frequency is important as there is some correlation with severity of stenosis particularly if the bruit spills into diastole. A common carotid artery occluded proximally may remain palpable. Evidence of collateral flow is difficult to gain by palpation and is best accomplished with a Doppler probe at the time of noninvasive studies.

The significance of bright plaques in the retinal arterioles described by Hollenhorst[13] is sometimes an overlooked manifestation of carotid artery disease. Among 235 patients who had occlusive disease within the carotid arterial system and 93 patients with clinical signs and symptoms of involvement of the vertebral basilar arterial system, 31 (9.4%) had a single to several dozen bright plaques. They were orange, yellow or copper and situated at various bifurcations of the retinal arterioles. They were often asymptomatic and some occurred perioperatively during carotid endarterectomy. These are thought to represent cholesterol crystals or a more liquid form that are visible evidence of arterial embolization from the more proximal carotid vessels. Rarely, the plaques are white and apparently represent bits of calcium. Thus, one should look diligently by means of ophthalmoscopic examination with dilated pupils in patients with suspected extracranial vascular disease.

What is the clinical meaning of an asymptomatic carotid bruit?

Studies[14-17] indicate that an asymptomatic carotid bruit is basically a sign of generalized widespread and often severe arteriosclerosis. The likelihood of subsequent stroke is much higher than in the general population and chances of subsequent myocardial infarction or sudden death from coronary disease is even higher. The distribution between men and women was variable. The percentage of patients with asymptomatic bruits increased with age from 3.5% in those 44 to 54 years to 7% at 65 to 79 years. While strokes and TIAs were significantly more common in patients with carotid bruits, in those prospectively the location of the strokes, and mechanism of the stroke was often such that it could not be related to presumed arterial narrowing at the site of the carotid bruit. It was more frequently hemorrhage from aneurysm, lacunar infarction and embolism from the heart than cerebral infarction in the carotid artery territory. Deaths from myocardial infarction were 2.5 times normal. The findings of the Framingham study[16] questioned the wisdom of seeking out carotid bruits in asymptomatic persons since two thirds of the strokes that would be expected to develop could not be prevented by carotid endarterectomy. Perhaps the bruit should be considered a marker of atherosclerotic cardiovascular disease. There have been problems in defining what a carotid bruit is,[14] i.e., 17-49% of cervical bruits are not due to carotid artery stenosis. The probability of finding a carotid bruit is about 27% in all patients with proven carotid artery disease and only 44% in those with known stenosis of 50% or greater. The absence of a bruit should not in any way lead to the conclusion that carotid vascular disease is not present. The meaning of "asymptomatic" has also been confused.[14] Asymptomatic in various studies has included patients with: (1) no neurologic symptoms whatsoever, (2) nonhemispheric symptoms, and (3) patients with bilateral disease on angiography after surgery on the symptomatic side. It is not definite that there is a difference among patients who have a bruit determined on population screening studies versus those found to have a bruit following referral because of a TIA or other cardiovascular symptoms.

What should you do if you discover a carotid bruit in an asymptomatic patient? Does such a patient need arteriography, noninvasive studies or both? Does an individual necessarily need either type of investigation?

With a convincing reproducible bruit you need to demonstrate whether or not it is there because of carotid vascular disease. The best technique is direct studies (carotid duplex scan) consisting of both Doppler ultrasonography and real time (B-mode ultrasound.)[1] Sensitivity is 90-99% and specificity 80-90%. Through all grades of disease from normal to total occlusion accuracy is between 80% and 90% when compared to angiography. If the patient is found to have significant vascular disease in the carotid bifurcation, then serial studies at approximately six months to one year intervals will be required to detect progression of asymptomatic disease. Angiography has become somewhat safer by virtue of additional technical developments and wider availability of trained physicians.[2] Digital subtraction techniques have added safety as well. If high grade carotid stenosis is observed and endarterectomy is considered, cerebral angiography is indicated[9] in addition to radiographs of extracranial vessels. Cerebral angiography provides

biplane images of the intracranial vasculature and remains the procedure of choice for intracranial vessels. Since collateral circulation is critically important and there is an interface of four different arterial supplies, some understanding of patency and adequacy of other vessels forming the circle of Willis is required.

Since an asymptomatic carotid bruit could be associated with carotid stenosis and/or represent a marker of atherosclerotic disease, evaluation of risk factors and appropriate treatment are indicated.

What about a carotid bruit and the risk of a stroke in elective surgery?

This seems to have been answered by Ropper,[18] in that, except for coronary artery bypass surgery, the perioperative stroke rate in patients undergoing a wide variety of surgical procedures was very small and, in fact, no greater than the risk from arteriography. All patients who had a stroke had coronary bypass operations and the mechanism of stroke was thought to be embolic from a more proximal source, either the heart or ascending aorta. Therefore, a carotid bruit discovered incidentally prior to required elective surgery would not require further action at the time of operation. Once surgery is completed, one would probably want to study the patient noninvasively simply to exclude severe carotid stenosis. Risk factors for atherosclerosis should be identified and treated.

How safe is it to follow patients with proven carotid stenosis without symptoms? What is the prognosis? What does natural history data tell us?

It is relatively safe to follow patients. Chambers et al[8] report a very low incidence of stroke in patients with carotid artery stenosis verified by continuous wave Doppler ultrasound. Severity of stenosis was an important predictor of cerebral and cardiac ischemic events and progression of carotid artery disease. If stenosis was less than 75%, risk of cerebral ischemic symptoms was less than 1% per year. Severity and progression should be monitored by noninvasive means periodically. When severe stenosis (75% or greater) is found or develops the patient should be advised to report any TIA symptoms promptly in anticipation of angiography/surgery or surgery should be considered on the basis of severity of the lesion itself. The degree of stenosis on initial presentation was a powerful predictor of neurologic sequallae.[8] Coronary artery disease and death were more common outcomes than cerebrovascular disease in the Chambers' study.

In an attempt to define the unknown natural history of symptomless tight stenosis of the internal carotid artery, Bogousslavsky[19] studied 38 patients with asymptomatic carotid bruit found to have stenosis of the internal carotid artery greater than 90% by Doppler. Only two patients suffered a cerebral infarct ipsilateral to the stenosis without any warning TIAs; 14 suffered ispilateral TIAs. These 14 patients were subsequently followed for a mean period of 20 months. The ipsilateral infarct rate was 2% per year in the presence of warning TIA. The risk of suffering an ipsilateral infarct without warning TIAs, calculated from a mean follow-up of 37 months, was 1.7% per year. Thus, even severe stenosis is seldom followed by an ipsilateral stroke. Carotid artery stenosis often progresses and carotid arteries frequently occlude without symptoms. Chambers[8] reported that carotid artery stenosis in 18 patients progressed to total occlusion but only ten patients had symptoms.

Two studies[20,21] reported on patients with totally occluded carotid arteries observed longitudinally to determine the incidence of stroke. In both, stroke occurred two thirds of the time ipsilateral to site of the occluded vessel and the rate varied between 3% and 5% per year. The rate for all patients 35 years and older was eight times that of a normal matched population.

It has frequently been pointed out that while 50% of cerebral infarctions have warning symptoms the other 50% do not. Warning symptoms may give the physician time to act but infarctions without warning cannot be predicted except by clinical and laboratory finding of severe carotid stenosis.

In an angiographic and clinical study Pessin et al[22] found two basic mechanisms of cerebral infarction. One strongly suggested an embolism in the cerebral vessels supplied by the stenotic or occluded carotid artery. Many of these patients had no warning (TIA) prior to the episode and experienced a moderate to severe neurologic deficit. The other showed absence of embolic features, evidence of low cerebral perfusion, frequent warning (TIA) and milder neurologic deficits. The opportunity for diagnosis was greater in the later group, and paradoxically the prognosis was more favorable.

Conflicting literature abounds. Even without investigative study, asymptomatic patients with bruits and known peripheral vascular disease matched with patients without bruits[23] did not have an increased risk of sudden stroke. Noninvasive assessment of the degree of stenosis did not help to predict which patients would have a sudden stroke.

Is there a case to be made for conservatism relative to carotid surgery?

Certainly there is in the asymptomatic patient with carotid stenosis less than 75%. Several investigators[19,23-26] argue for a conservative approach in these patients.

It seems true that as a stenosis worsens, transient ischemic attacks increase but the stroke incidence relative to the site of the lesion remains fairly low. A prospective study of internal carotid occlusion[27]

does not present a particularly ominous picture but the stroke rate distal to the occluded vessel increased to 5% per year. When carotid stenosis becomes symptomatic in the form of TIAs or reversible ischemic neurologic deficits (RINDs) or mild completed strokes, there is more uniformity of agreement regarding the need for surgery.[28]

If the patient has a transient ischemic attack and severe stenosis (more than 75% luminal narrowing), carotid endarterectomy may be the best treatment although proof from randomized controlled trials is unavailable. For less severe stenosis in symptomatic patients, we do not yet know the relative benefits of aspirin, other anticoagulants, or surgery. One of the most difficult problems in the whole area of decision making about the need and indication for surgical therapy is the balancing of risk. Angiography and carotid endarterectomy have a mortality rate of about 1% and a cerebral infarction rate of approximately 2-3%. If the likelihood of cerebral infarction is only 1-3% per year in certain patient groups it may be difficult to justify a vigorous surgical approach unless higher risk groups can be defined.

Whether there is a relationship between carotid artery disease and actual cerebral infarction is debatable. It does seem that there is a relationship between the degree of carotid artery disease and the likelihood of further symptomatic episodes, namely TIA.

What about simultaneous disease in other vascular beds?

This is a complicated question. Some papers have called attention to the interrelationship of manifestations of atherosclerosis[29,30] and many strategies have been advocated, including simultaneous surgery for both carotid and coronary disease. From the natural history of a patient with TIA, the event may be a serious warning of all the complications of generalized atherosclerosis, just as a carotid bruit represents a sign of generalized vascular disease. If a major proportion of deaths after TIA are caused by cardiac disease, should we not investigate and treat the heart as aggressively as we try to protect the brain in the patient with TIAs?

Does risk factor reduction make a difference in treatment of carotid artery disease?

I think the answer is clearly yes.[31,32] The stroke incidence has markedly declined over time and the most clear-cut factor seems to have been treatment of hypertension. Some consider this to be the only significant contributor to the decline of stroke.[31] Other risk factors correlated with carotid vascular disease are cigarette smoking, serum lipids, coronary heart disease, and diabetes mellitus. None appear as important as hypertension which has been prevalent enough and the effect of treatment powerful enough to account for the extent of the decline of stroke incidence. Aggressive treatment of hypertension is warranted as well as modification of other usual known risk factors.

What is the expertise level in your institution with carotid duplex scanning? What is the experience in your institution relative to morbidity and mortality from angiography and carotid endarterectomy?

The physician doing the Doppler and B-mode images of the carotid bifurcation must be trusted for accurate diagnosis. There must be substantial agreement with angiography. Angiographic studies must include not only the carotids and vertebrals but intracranial as well so as to assess the entire circulation and extent of collateral filling. Since the risk of stroke is very low, the mortality and morbidity of carotid endarterectomy and angiography together must not exceed 1% to 3% or the risk of the procedure may outweigh the risk of stroke in some settings. These questions should be assessed and answered before proceeding with a more aggressive approach.

What is the current status of aspirin and other antiplatelet drugs for prophylaxis of TIA?

The principal aim of treatment is to prolong survival free of stroke. Thus, therapy is designed to prevent stroke through reduction of risk factors, prevention of initial or recurrent stroke by eliminating or modifying the underlying pathologic process, and reduction of secondary brain damage by maintaining adequate profusion to marginally ischemic areas.[33]

Treatment of TIA is preventative. It includes aspirin and other antiplatelet drugs. Clinical trials over the last decade have clearly shown aspirin to be an effective antiplatelet agent. It is a powerful inhibitor of platelet aggregation possessing two effects relevant to thrombosis. First, aspirin acetylates platelet prostaglandin synthetase which is responsible for conversion of arachidonic acid to thromboxane A_2, a potent inducer of platelet aggregation and vasoconstriction.[34,35] Second, it inhibits the synthesis of prostacyclin (PGI_2) in the vascular wall. Prostacyclin inhibits platelet aggregation, and promotes smooth muscle relaxation and induces vasodilation.[36-38] Ideally, the aspirin dosage should inhibit thromboxane A_2 synthesis without affecting prostacyclin synthesis. These effects are uniquely confined to the acetyl moiety of aspirin. Sodium salicylate neither prolongs the bleeding time nor significantly inhibits platelet ADP release. Aspirin causes acetylation of the platelet enzyme and this effect lasts for the life of the exposed platelet, normally eight to ten days.[39-41]

Aspirin therapy for prevention of cerebral ischemia is based on positive results from several

clinical trials. Six randomized trials of long-term therapy in TIA and/or minor stroke patients have been published. Of special interest are the American and Canadian reports of reduction or cessation of transient ischemic attacks and prevention of cerebral infarction.[44]

Clinical trials of aspirin as an antiplatelet drug pose an unusual dilemma. It is widely used and easily accessible, making a properly conducted controlled trial difficult without the risk of nontrial ingestion.

The American trial studied 178 patients, selected at random, who had one or more transient ischemic attacks. It compared the effects of aspirin 600 mg twice daily with a placebo. There was only a suggestion of a trend favoring the use of aspirin in patients with one prior TIA. Among patients with multiple TIAs there was a significant reduction in the number who suffered at least one of the absolute endpoints compared with the placebo group. Absolute endpoints were subsequent TIAs, death, cerebral infarction or retinal infarction. Significance favoring aspirin treatment was mainly revealed in patients with a history of multiple TIAs and was most evident in those having carotid lesions appropriate to the TIA symptoms.[42]

In the Canadian cooperative study, 585 patients with transient ischemic attacks were followed for an average of 26 months. They were randomized to one of four regimens taken four times daily consisting of a 200 mg tablet of sulfinpyrazone plus a placebo capsule, a placebo tablet plus a 325 mg capsule of aspirin, both active drugs, both placebos. In the aspirin-treated group, there was a 19% lower incidence of strokes, TIAs or deaths and a 31% reduction when stroke and death were considered together. Sulfinpyrazone was ineffective when used alone and had no synergistic effect with aspirin. When men and women aspirin-treated populations were analyzed separately, this beneficial effect was confined to men in whom stroke morbidity and mortality rates were reduced 48%. The number of women in the trials was about one third the men.[44] On the basis of these two trials, the FDA has approved the use of aspirin in men with threatened stroke who are not candidates for surgery and not receiving concurrent anticoagulant therapy.

The AICLA trial of aspirin and dipyridamole in the prevention of cerebrovascular accidents confirmed the findings of the Canadian study. A total of 604 patients with atherothrombotic cerebral ischemic events (transient 16% or completed 84%) referable either to the carotid or vertebrobasilar circulation were entered into a double-blind randomized clinical trial (AICLA) to determine whether aspirin 1 gram per day or 1 gram per day plus dipyridamole 225 mg per day would produce a significant reduction in the subsequent (three years) occurrence of fatal and nonfatal cerebral infarction. Aspirin 1 gram had a significant beneficial effect in the secondary prevention of atherothrombotic cerebral infarction.[45]

Why men benefit from aspirin and women do not remains unexplained. This differential response has been shown in some animal species. The reason could be the different effects of aspirin on the fibrinolytic system, platelet prostaglandin synthesis, or platelet-vessel wall interaction. A second explanation may be the differing sensitivity of male and fcmale platelets to aggregating agents. Platelets from males of various mammalian species aggregate at lower concentrations than platelets from females. The reverse has been reported for human platelets.[46-49] Lastly, it is possible that the interaction of aspirin or platelets with the vessel wall is different in males.

Four additional randomized trials totaling 965 patients of long-term aspirin use in TIA and/or minor stroke have been published.[43,45,50,51] Each employed doses of approximately 1 gram per day and three were double blind. All had a population consisting of a higher proportion of women than men. Each showed a reduction in the risk of stroke; however, the results were not statistically significant.

The optimal antithrombotic dose of aspirin is the basis of considerable controversy. Low doses, 300 mg or less, have a selective inhibitory effect on thromboxane A_2 and, thus, produce significant effects on platelet aggregation. It has been reported that aspirin interferes with conversion of arachidonic acid to thromboxane A_2 in platelets in a dose approximately one tenth of that necessary to inhibit the conversion of arachidonic acid to prostacyclin.[52] Since thromboxane A_2 is proaggregatory and prostacyclin is antiaggregatory, theoretically it would be advantageous to block the former and spare the latter. It has been suggested that low doses of aspirin will produce maximal inhibition of thrombosis and that inhibition of prostacyclin by aspirin is of shorter duration than that of thromboxane A_2.[53] Aspirin acetylates the enzyme irreversibly and platelets cannot synthesize new enzymes. Endothelial (prostacyclin limb) cells regain this ability within hours after the last dose of aspirin and recover fully within 36 hours.[54,55] Consequently, some investigators recommend one or two 325 mg aspirin tablets in a single daily dose to maximize the antagonism of thromboxane A_2 production by platelets while minimizing inhibition of prostacyclin production by vascular endothelium.[54] Low doses would be desirable since many side effects of aspirin are dose dependent. Scientifically, the relationship between the optimal dose of aspirin and antithrombotic effectiveness has yet to be shown.

Studies of aspirin's effect on thromboxane and prostacyclin synthesis have shown that doses as low as 1 mg per kilogram daily for 15 days decreases thromboxane production 15%.[56] Maximal production inhibition was achieved at doses of 325 mg daily and greater and those were associated with maximal effects on platelet function. These doses also maximally decreased prostacyclin production. Thus, aspirin doses greater than 80 mg daily inhibit prostacyclin biosyn-

thesis and greater than 160 mg daily maximally inhibit thromboxane A_2 production.[57] The extent to which thromboxane A_2 must be inhibited in order to reduce the risk of thrombosis is unknown.

The answer to the question, what dose of aspirin to use, should be available soon. The results of the long-awaited United Kingdom TIA trial are currently being reviewed.

Aspirin has been shown effective in reducing the rate of strokes. The question is whether an additional antiplatelet aggregating drug will act synergistically to enhance the protection afforded patients against stroke. Published reports on patients with artificial cardiac valves and implanted shunts for renal dialysis indicate that a combination of aspirin and dipyridamole reduces platelet embolization.[59-62] Would the fact that these drugs act differently — aspirin as an inhibitor of prostaglandin synthetase function and dipyridamole as a phosphodiesterase inhibitor - indicate that certain combinations might be more effective?

Dipyridamole inhibits ADP release through inhibition of phosphodiesterase in platelets which blocks the breakdown of cyclic AMP and ultimately exerts an inhibitory effect on platelet adherence and aggregation to damaged vessel walls.[63-65] In vitro, dipyridamole seems to have additive antiplatelet effects when combined with aspirin. In vivo, however, the combination has not shown greater clinical efficacy than aspirin alone.[45]

Dipyridamole has been used to prevent thrombotic complications in patients who have undergone coronary artery bypass graft, prosthetic valve surgery, had a recent myocardial infarction or stroke, or who have significant atherosclerotic disease. A clinical trial using 400 or 800 mg per day revealed no significant differences between dipyridamole and placebo in preventing TIA, stroke or death.[66]

No evidence exists to support prescribing dipyridamole after TIA or embolic stroke unless there is clinical or laboratory evidence of atherosclerotic disease in the carotid or vertebral circulation. Dipyridamole, administered concomitantly with aspirin, may be effective as antiplatelet therapy. Improvement in morbidity and/or mortality has not been shown.[67] Perhaps the combination of aspirin and dipyridamole, which theoretically should be more effective than either alone, has been tested in the wrong doses, or trial populations were too small to detect benefits, or possibly the follow-up period was too short. Although further trials are now in progress, only aspirin has been found to be an effective antiplatelet agent for stroke and TIA prevention.

In the Canadian aspirin trial the addition of sulfinpyrazone to aspirin appeared promising but was not statistically significant.[44] Like aspirin, sulfinpyrazone inhibits cyclooxygenase. Clofibrate has also been studied but did not decrease the incidence of TIAs.[68]

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Current Status of Carotid Endarterectomy in Prevention of Stroke

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ABSTRACT: ***Carotid endarterectomy has been successfully utilized in stroke prevention for more than 30 years; however, there are concerns regarding its effectiveness, alleged overuse, and perioperative morbidity and mortality rates. From a practical standpoint, the controversy has created considerable confusion as to the current role of carotid endarterectomy in the stroke-prone patient. Accordingly, this paper provides an up-to-date consensus of surgical opinion regarding the pathophysiology of carotid atherosclerosis; indications for carotid endarterectomy in terms of what is generally accepted or considered controversial; risks factors to be evaluated in selection of patients for operation; and results of surgery including a discussion of what constitutes "acceptable" perioperative morbidity - mortality. The benefit of carotid endarterectomy is closely related to safe conduct of the operation. Consequently, since the risk varies among surgeons, it is important that individual surgeons and hospital audit committees continuously monitor carotid endarterectomy procedures to ensure that acceptable results are achieved and maintained.***

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Despite reports of a substantial decline in incidence since 1945,[1-4] stroke continues as a leading cause of death in the United States. Annual incidence is an estimated 400,000 cases[5] and costs at $15 to $20 billion dollars per year.[6] Approximately two of every five persons who suffer a stroke die within the first 30 days and one half of those who survive for a longer period require special care.[7] At present, there are about two million surviving stroke victims in the United States.[8]

The majority of stroke patients have significant atherosclerotic stenosis or occlusion of the extracranial arteries.[9] Predeliction sites include the carotid bifurcations, origins of the internal carotid arteries, and the origin and along the course of the vertebral arteries.[10-13] Although most patients present with lesions in more than one arterial bed, nearly half the strokes in this country are associated with an atherosclerotic plaque occurring within 3 cm of the bifurcation of the common carotid artery.[14]

For over 30 years, endarterectomy of the carotid bifurcation has been utilized as a means of stroke prevention.[15] The number of procedures has increased steadily from approximately 17,000 in 1971 to 100,000 in 1984.[16,17] Carotid endarterectomy has become the most commonly performed peripheral vascular procedure in the United States and reports indicate that operations in asymptomatic patients account for up to 50% of the total procedures.[18,19]

Within the past few years, considerable controversy has arisen, mostly generated by prominent and influential neurologists, as to the efficacy of carotid endarterectomy in preventing stroke.[16,17,20-25] Concerns have been expressed regarding (1) the indications for operation; (2) high operative morbidity and mortality in various community hospitals; (3) comparative effectiveness for stroke prevention versus medical

management with control of risk factors; and (4) the need for adequate and controlled prospective randomized studies to provide scientific answers for unresolved questions.

In recognition of the magnitude of the stroke problem and the controversial issues raised by neurologists about treatment, this paper reviews current surgical thinking with respect to the use of carotid endarterectomy in stroke prevention. Although opinions naturally vary, an attempt is made to provide information indicating what is generally accepted as opposed to what is generally controversial among most vascular surgeons. Special attention is devoted to the pathophysiology of stroke, current indications for carotid endarterectomy, selection of patients for operation in terms of risk factors, results of surgery, and new developments related to the treatment of stroke caused by carotid atherosclerosis.

Pathophysiology ● Studies of carotid blood flow show that it divides sharply at the carotid bifurcation with some blood curling backward in the carotid sinus toward the heart.[26] The boundary layer phenomenon this pattern creates occurs precisely at the point where the atherosclerotic lesion begins in the carotid artery. Recent work by Zarin[27] supports the concept that the carotid bifurcation plaques localize in regions of low flow velocity and separation; not in regions of high velocity and elevated shear stress as previously reported.

The two basic mechanisms whereby carotid atherosclerosis produces cerebral ischemia are embolization usually, but not exclusively, related to an ulcerated plaque and a significant reduction in blood flow resulting from narrowed or occluded carotid arteries. It is generally agreed that about 80% of ischemic events have an embolic basis. Emboli consist of hematogenous clots (often platelet aggregates) and/or atheromatous material (cholesterol crystals, calcific particles, thrombotic remnants). Such emboli originate from sites where blood flow is slowed and turbulent, e.g., an irregular luminal surface or an ulcerated plaque with or without a significant arterial stenosis, and also from degenerative plaques that rupture with resultant discharge of contents.

In considering the pathogenetic mechanism of ischemia caused by flow-limiting carotid stenosis, it is necessary to define a hemodynamically significant lesion. Experimentally, a hemodynamically significant stenosis is characterized by a 10% decrease in distal mean flow and a 5% fall in distal mean pressure.[28,29] According to both May[30] and Barnes,[31] a stenosis of the carotid artery does not result in a significant decrease in pressure until it exceeds a 50% reduction in arterial diameter. Crawford[32] also concludes that a hemodynamically significant decrease in flow is associated with a 50% stenosis which corresponds to a 75% reduction in cross-sectional area. On the other hand, Young[33] and Moore[34] indicate that a significant stenosis is not a fixed percentage since it varies with the flow rate and distal arterial pressure. Thus, while no absolute stenosis can be designated as hemodynamically significant, it is generally conceded that at least a 50% diameter-reducing stenosis is required.

Recently, there has been a great deal of interest in the pathologic composition of carotid plaque in terms of its prognostic significance. This has been stimulated by the observation that plaques removed from patients with transient ischemic attacks or stroke are more likely to be hemorrhagic than those removed from asymptomatic patients.[35-38] Intraplaque hemorrhage, which often occurs spontaneously or after minor trauma, may cause a sudden increase in the degree of stenosis (by virtue of the enlarged hemorrhagic plaque) or intraluminal disruption of the plaque with subsequent embolization and formation of an ulcer. Severely stenosing lesions frequently have more degenerative features because of their "age", and are usually associated with a greater patient morbidity.[36,37,39-41] In addition, a so-called "soft plaque" (depicted as a faint ultrasound echo on noninvasive testing) is more likely to ulcerate, bleed and discharge its contents than a firm fibrocalcific lesion.[42,43]

Classification of patients ● Patients with carotid atherosclerosis are customarily classified into specific clinical categories based on the presence or absence of various neurological ischemic syndromes. As emphasized by Thompson,[44] such classification is important for proper selection of patients for operation and comparison of results of different methods of therapy within the same category. Notwithstanding some descriptive differences in the literature, the following classification would appear to encompass the generally recognized categories (Table 1).

Table 1.—Clinical Classification of Patients.

Asymptomatic
Transient Ischemic Attack (TIA)
Completed Stroke
Chronic or Generalized Cerebral Ischemia

1. Asymptomatic: By definition, these patients have a proven hemodynamically significant carotid lesion or a nonocclusive ulcerated plaque in the absence of neurological symptoms.[45] They are usually discovered either by angiography in studying other conditions or noninvasive studies performed because of a cervical bruit or screening prior to major surgical procedures.

In the past, the subject of asymptomatic patients has been addressed by using the presence of a cervical bruit alone, i.e., without a documented significant lesion, as the sole criterion. However, studies have shown that this approach inevitably results in the

inclusion of many patients without significant occlusive disease and omission of others without a cervical bruit but with significant lesions in their extracranial circulation.[46,47] In an analysis of 1,287 patients with carotid bruits, Kartchner[48] found that less than one third had a hemodynamically significant lesion by noninvasive criteria. Consequently, a carotid bruit is not synonymous with a hemodynamically significant stenosis; on the other hand, the presence of a carotid bruit should be viewed as a general marker of a patient at high risk for atherosclerosis.[49]

2. Transient Ischemic Attack (TIA): Patients in this category experience a transient neurological deficit lasting less than 24 hours with complete recovery. Since a TIA can be caused by either carotid or vertebrobasilar ischemia, it is important to ascertain the symptomatology as accurately as possible. A TIA within the carotid system (territorial TIA) characteristically produces hemispheric and/or monocular symptoms (contralateral motor or sensory disturbances, possible speech defects if dominant hemisphere involved, and ipsilateral amaurosis fugax). Vertebrobasilar TIAs may involve deficits of cranial nerve function, disorders of equilibrium, homonymous hemianopsia, and unilateral or bilateral synchronous or asynchronous motor or sensory deficits.

3. Completed stroke: This denotes the occurrence of a cerebral infarction with death of neuronal tissue. Surviving patients may have a permanent neurological deficit or incomplete or complete recovery.

4. Chronic or generalized cerebral ischemia: Patients in this category have generalized nonfocal cerebral hypotension associated with multiple occlusive involvement of major extracranial vessels. "Global" symptoms include postural lightheadedness, faintness and occasional syncope, unsteadiness of gait and transient dimness of vision.

In addition to the previously mentioned categories, it is useful from the standpoint of both management and prognosis to classify patients according to the presence of (1) an acute stroke; (2) a progressive stroke or stroke in evolution; and (3) repetitive crescendo TIAs.

Berguer[39] recently emphasized that the traditional clinical classification of cerebrovascular disease is limited since it takes into account only the part of the brain that has somatic representation. In a study designed to correlate clinical neurological presentation with CT scan findings, he found a 19% incidence of unsuspected infarction among patients with a history of TIAs alone. Because of this disparity, he concluded that clinical and CT findings should be included in studies investigating the consequences of carotid disease or carotid endarterectomy.

Indications for carotid endarterectomy and timing of operation ● In presenting this material it should be clearly understood that legitimate differences of opinion, based on individual and institutional experience, exist among accomplished and respected vascular surgeons. Notwithstanding such differences, a review of the literature and personal communications with leading surgeons lead me to conclude that the indications for carotid endarterectomy as enumerated by Moore[45] (Table 2) represent a reasonable overview of the majority of mainstream sentiment.

Table 2.—Indications for Carotid Endarterectomy.

Accepted Indications
- a. Hemispheric and/or monocular TIAs

Accepted Indications — with Reservation
- a. Hemispheric completed stroke with good recovery
- b. Global ischemic symptoms with multiple arterial occlusive lesions

Controversial Indications
- a. Asymptomatic carotid stenosis
- b. Asymptomatic large carotid ulceration
- c. Progressive intellectual impairment with demonstrable multiple arterial occlusive lesions
- d. Acute stroke within the first few hours of occurrence
- e. Stroke in evolution or waxing and waning deficit
- f. Vertebrobasilar symptoms with combined carotid and vertebrobasilar disease

Accepted indications

A. Hemispheric and/or monocular TIAs. Patients with territorial TIAs and appropriate lesions of the carotid bifurcation are considered the best candidates for carotid endarterectomy. Most surgeons define an appropriate lesion as either a carotid stenosis equal to or greater than 50% or a nonstenotic ulcerative plaque believed to be the source of cerebral emboli causing the patient's symptoms.

Accepted indications — with reservation

A. Hemispheric completed stroke with good recovery. Patients who have suffered a prior stroke in the territorial distribution of a diseased internal carotid artery, i.e., an appropriate surgical lesion, and have made a good recovery with minimal to modest neurological deficit are considered candidates for carotid endarterectomy provided the distal internal carotid artery is still patent.

B. Global ischemic symptoms with multiple arterial occlusive lesions. Patients with symptoms of global ischemia or vertebrobasilar ischemia and who are found to have high grade stenoses of the internal carotid artery appear to be suitable candidates for symptomatic relief by carotid endarterectomy.

Controversial indications

A. Asymptomatic carotid stenosis. Although the natural history of patients with hemodynamically significant carotid stenoses has not been clearly defined, several reports suggest that noninvasively identified high grade stenoses (≥75-80%) may be at increased risk of stroke. Busuttil[50] observed a 6.6% incidence of stroke during a 2½ year follow-up period in patients with noninvasively documented hemodynamically significant carotid stenoses; there were no strokes in those patients with negative noninvasive studies. Chambers and Norris[24] cited a 15% annual neurological event rate in patients with carotid stenoses ≥75% compared to a 3% annual rate in patients with lesser stenoses. In a longitudinal study utilizing Duplex scanning to identify and follow significant carotid stenoses, Roederer[51] found that the progression of a lesion to greater than 80% stenosis carries with it a 35% risk of ischemic symptoms or ipsilateral occlusion within six months or a 46% risk at 12 months.

In a collective review of asymptomatic carotid disease, Long[52] stated that specific groups that appear to be at greatest risk include patients with stenoses greater than 80%, patients who demonstrate progression on serial noninvasive evaluation, those with poorly compensated lesions by OPG testing, and patients with large complex ulcerations. While these groups should encompass those patients most at risk for developing a stroke as a first clinical manifestation of their carotid stenosis, it should be pointed out that the majority within these groups will present initially with TIAs. Until more definitive data are available from prospective randomized studies, Hobson[53] recommends that prophylactic endarterectomy be confined to better risk patients with high-grade stenoses. Also, it is essential that any surgeon contemplating carotid endarterectomy for selected asymptomatic patients demonstrate combined morbidity and mortality figures of less than 3%.[52]

In patients who have previously undergone carotid endarterectomy for symptomatic disease and are known to have an asymptomatic contralateral stenosis, a number of reports[54-58] suggest that those with stenoses less than 75% can be safely managed nonoperatively. Even though a significant percentage (12%) will eventually become symptomatic, the overwhelming majority will experience warning TIAs. Hence, carotid endarterectomy is usually reserved for patients in whom TIAs subsequently develop or progression of disease is greater than 75% stenosis on follow-up noninvasive studies. Sobel[59] underscores the need for careful follow-up since on occasion stroke may outnumber TIAs as a presenting symptom.

The controversy regarding appropriate management of patients with asymptomatic carotid stenoses discovered prior to anticipated major surgery will be resolved only when the natural history is better understood and the relative efficacy of medical and surgical treatment is clarified. Intraoperative hypotension combined with carotid occlusive disease is the mechanism most often postulated as responsible for cerebral hypoperfusion and stroke. However, Hart and Hindman[60] on the basis of their own experience and reviews of the available literature concluded that 83% of strokes occurred in the postoperative period and were unrelated to hypotension; that carotid occlusive disease was not predictive for perioperative stroke; and that cardiogenic emboli and/or altered coagulability in the postoperative period were of potential etiological importance. At present, the literature suggests that patients with asymptomatic carotid disease are not at significant risk of perioperative stroke but do require careful follow-up because of an increased risk of late postoperative neurological deficits.[61-63] Nevertheless, since the perioperative risk of stroke within a wide range of stenoses has not been well defined,[64] there are those who feel that selected asymptomatic preoperative patients with a severe stenosis should be considered for carotid endarterectomy prior to the original planned procedure.

B. Asymptomatic, large carotid ulceration. Carotid ulcers are classified as "A", minimal discrete ulcerations; "B", large obvious ulcerations; and "C", complex, multiple ulcerations.[65,66] There is a general consensus that asymptomatic "A" ulcers do not represent a significant stroke risk to the patient. Category "B" ulcers are controversial with respect to risk and treatment. Previous natural history studies have shown that "C" ulcers carry a 7.5% per year stroke risk. Accordingly, some surgeons advocate carotid endarterectomy for asymptomatic patients with "C" ulcers.[67,68]

C. Progressive intellectual impairment with demonstrable multiple arterial occlusion lesions. Although intellectual impairment may be associated with a decrease in cerebral blood flow due to stenosis or occlusion of the extracranial arteries, carotid endarterectomy has not been shown to reliably improve neuropsychological performance.[69]

D. Acute stroke within the first few hours of occurrence. Carotid endarterectomy is no longer commonly used for treatment of the acute stroke. However, in case of acute carotid thrombosis following arteriography or carotid endarterectomy, surgery is probably justifiable and worthwhile if it can be performed immediately (within one or two hours).[44,70]

E. Stroke in evolution or waxing and waning deficit. Patients suffering progressive ischemic symptoms and found to have an unstable carotid lesion represent a very high risk group for either medical or surgical management. Surgeons familiar with management of these patients can reduce stroke risk by carotid endarterectomy.[71,73]

F. Vertebrobasilar symptoms with combined carotid and vertebrobasilar disease. Although carotid endarterectomy has been advocated for patients with vertebrobasilar disease who also have carotid stenosis,

long-term follow-up studies usually have not demonstrated sustained symptomatic relief.[74] In a study by Ouriel,[75] however, carotid endarterectomy proved more successful in ameliorating symptoms in patients with "classic" vertebrobasilar ischemia and a carotid stenosis greater than 60%.

The majority of clinical conditions for which carotid endarterectomy is indicated permit operation on an elective basis. Nevertheless, there are some situations in which appropriate timing is of the utmost importance in order to obtain a favorable outcome. Previous reports have shown that carotid endarterectomy within two weeks of a completed stroke is associated with a high morbidity and mortality presumably from hemorrhagic complications in the brain.[76-78] Although the optimal timing for carotid endarterectomy after stroke is unknown, Giordano[79] suggests that an unstable situation in the five week interval following stroke contraindicates operation. Thus, it is probably wise to delay operation at least five weeks in patients with a completed stroke and significant neurological deficit. Emergency carotid endarterectomy is rarely necessary but may be indicated in special circumstances, e.g., crescendo TIAs, TIAs caused by severe carotid stenosis especially if bilateral, and carotid thrombosis immediately following arteriography or endarterectomy.[44] Patients with symptomatic carotid lesions scheduled to undergo other major surgery should have a preliminary carotid endarterectomy depending upon the indications and urgency of the originally planned surgery. Occasionally, it is necessary to perform carotid endarterectomy simultaneously with other procedures in unstable patients, e.g., TIAs in the patient scheduled for coronary artery bypass because of unstable angina.[80] In patients with significant bilateral carotid lesions that require surgical correction, the procedures should be staged at least one to two weeks apart or even longer.[44] Schroeder[81] reports that the incidence of postendarterectomy hypertension in patients undergoing staged bilateral endarterectomy was significantly higher following the second procedure when operations were staged less than three weeks apart.

Selection of patients for operation — risk factors ● In selecting patients who might potentially benefit from carotid endarterectomy, many factors should be considered. These include (Table 3): the patient's neurological status; natural history of the untreated condition; presence of associated diseases (especially coronary atherosclerosis and hypertension) and their severity; risk of diagnostic ateriography; risk of surgery (specifically, incidence of perioperative stroke and death); and long-term results of both surgical treatment and alternative forms of therapy.

Patients with little or no neurological deficit are at less risk for operation than patients with significant functional impairment. Also, those patients neurologically unstable constitute a major surgical risk. It is generally agreed that patients with acute profound stroke and those with rapidly progressing strokes should not be considered for operative intervention; previous experience has shown that operation in such patients is associated with an inordinately high mortality rate (from 20% to 60%).[44]

Table 3.—Factors to be Considered in Selection of Patients for Carotid Endarterectomy.

Patient's neurological status
Natural history of the untreated condition
Presence of associated disease (especially coronary atherosclerosis and hypertension)
Risk of diagnostic arteriography
Risk of surgery (perioperative morbidity and mortality)
Long-term results of both surgical and alternative forms of treatment

A high proportion of patients with carotid disease have coronary atherosclerosis and hypertension. Indeed, coronary artery disease is the leading cause of early and late mortality after carotid endarterectomy. In a study using routine coronary arteriography to evaluate 506 patients with carotid disease, Hertzer[82] found severe but surgically correctable coronary artery disease in 37% of patients. Although routine coronary arteriography is no longer recommended, all patients with carotid atherosclerosis are evaluated clinically with respect to the possibility of significant coronary disease. Appropriate cardiac screening and/or arteriography are utilized whenever indicated. There is a general consensus that patients with unstable angina, congestive heart failure or a history of recent myocardial infarction (within six months) should undergo coronary arteriography prior to elective carotid endarterectomy. A number of studies indicate that patients with a previous hypertensive history have a statistically significant risk for severe postoperative hypertension.[83-85] Since postoperative hypertension is associated with an increased incidence of both transient and permanent neurological deficits, carotid endarterectomy should be postponed until uncontrolled hypertension is corrected.[86-88] Sundt[89] has identified the following arteriographic findings as indicative of an increased operative risk: (1) occlusion of the opposite internal carotid artery; (2) stenosis of the internal carotid artery in the region of the carotid siphon (tandem lesion); (3) extensive involvement of the vessel to be operated on (extension of the plaque greater than 3 cm distally in the internal carotid artery or 5 cm proximally in the common carotid artery); (4) a high carotid bifurcation in conjunction with a short thick neck; (5) evidence of a soft thrombus extending from an ulcerated lesion; and (6) a high grade carotid stenosis. In a recent study of internal carotid occlusion and significant contralateral stenosis, Friedman[90] concluded that endarterectomy of the nonoccluded internal carotid

artery is the treatment of choice despite a slightly higher perioperative stroke and mortality rate than in patients with bilateral patent carotid arteries. With regard to a carotid siphon stenosis, several reports indicate that the embolic potential of a carotid bifurcation plaque far outweighs the thrombotic or embolic risk of the tandem lesion.[45,91] Thus, operation is indicated in most patients. In patients with a high grade stenosis, carotid endarterectomy produces a sudden increase in cerebral blood flow (luxury perfusion) that may result in "hyperperfusion syndrome."[70] This syndrome may take the form of ipsilateral vascular-type headaches, migraine variants, seizures or an intracerebral hemorrhage. The pathophysiology of "hyperperfusion syndrome" is believed to be related to preoperative loss of cerebral autoregulatory mechanisms caused by chronic cerebral ischemia.[92]

Results of surgery ● A discussion of the results of carotid endarterectomy necessitates a preliminary explanation of problem areas in the interpretation of data. To begin, the predicted incidence of stroke occurring after a TIA depends on several factors such as the age and sex of the population studied[93] and the type of TIA sustained. Some investigators suggest that amaurosis fugax carries a better prognosis than a cerebral TIA.[94,95] Thus, evaluation of the potential benefit of carotid endarterectomy should take into account these factors along with others that are less clearly associated with a greater risk of stroke.[96] It is also difficult to compare studies because definitions of neurological complications differ and follow-up information is often limited. Unfortunately, some studies do not indicate whether late stroke is ipsilateral or contralateral to the operated carotid artery. Valid studies should always include perioperative morbidity and mortality results since they represent a part of the effect of treatment and cannot be separated from long-term outcome. Finally, an accurate comparison of surgical results with both the natural history of the disease and medical treatment is limited by a lack of adequate prospective randomized studies.

There is general agreement among leaders in vascular surgery that combined perioperative morbidity (stroke rate) and mortality associated with carotid endarterectomy for patients with TIAs should not exceed 4% to 5%. Indeed, there is ample evidence that carotid endarterectomy in experienced hands (both in academic centers and community hospitals) can be performed in TIA patients with a perioperative stroke rate of 2% to 3% and a mortality of $\leqslant$1%.[44,70,96-99] In 1980 Harrison[100] calculated that to show an overall improvement on the natural history of TIAs, a surgical series must have a perioperative mortality rate of $\leqslant$1% and a combined morbidity-mortality no greater than 3% to 4%. The mortality rate of angiography (less than 0.5%) and the neurological risk of arteriograms (0.5-2.5%) were included in this calculation. Hass[101] analyzed the outcome of stroke in the Extracranial Arterial Occlusion Joint Study and calculated "acceptable risk," i.e., the maximal stroke rate after angiography and surgery, to be 2.9%. Operation for the prevention of recurrent stroke, i.e., patients with prior stroke and good recovery, carries a somewhat higher risk than that for TIA patients. Two recent studies cite combined morbidity-mortality rates of 5.1% and 4.5% respectively.[102,103]

As mentioned earlier, neurologists have expressed considerable concern regarding the high rates of perioperative morbidity-mortality (up to 21%) following carotid endarterectomy in certain community hospitals.[18,104-107] One group of neurologists has estimated a nationwide 10% major morbidity-mortality rate.[16] Obviously, such poor results are not acceptable since they negate any beneficial effect of surgery. While it has been assumed that the risk of carotid surgery is relatively equally distributed among surgeons, a review of the literature shows that this is clearly not the case. Consequently, the advantages of carotid endarterectomy will only be apparent in the hands of those surgeons who can perform the operation with a low morbidity and mortality as previously outlined.

The two objectives of carotid endarterectomy are to abolish TIAs and prevent stroke. With regard to TIAs, long-term functional results following carotid endarterectomy reveal that from 85% to 95% of these patients either have no further attacks or have fewer attacks of lesser severity.[44,96] An analysis of surgical series with suitable long-term follow-up shows that a successfully performed carotid endarterectomy, i.e., with acceptable perioperative morbidity and mortality rates, will significantly lower the risk of ipsilateral stroke in patients with TIAs or a history of prior stroke with good recovery. In TIA patients, successful operation reduces the annual stroke risk to 1% to 2% per year.[108-113] On the other hand, available natural history data on TIA patients suggest a stroke risk of 10% within the first year after onset of symptoms and 5% to 6% per year thereafter.[101,114] The late stroke rate following carotid endarterectomy in patients with a prior stroke is also reduced to 1% to 2% per year;[102,103,111-113,115] whereas natural history data for patients in this category indicate a stroke risk of approximately 9% per year.[68] At present there is insufficient data to justify a definitive statement regarding the efficacy of carotid endarterectomy for selected patients with asymptomatic carotid disease.

Over the years, carotid endarterectomy has proved to be a very durable operation. The incidence of recurrent stenosis lies somewhere between 9 - 19% depending upon the method of detection;[116,117] however, symptomatic recurrent stenosis occurs in only 0.5% to 3% of patients.[118] Restenosis within two years of operation is generally attributed to myointimal hyperplasia and restenosis occurring thereafter is due to atherosclerosis.[119] Although the exact cause of recurrent stenosis is unknown, it is

more commonly associated with patients of female gender, continuation of smoking after carotid endarterectomy, and known hyperlipidemia,[120] Interestingly enough, several authors have documented regression of early postoperative stenoses by duplex scanning and spectral analysis.[117,120,121] While the indications for surgery are controversial (especially in asymptomatic patients), it is my perception that most surgeons favor reoperation for symptomatic patients and asymptomatic patients with critical recurrent stenoses, i.e., greater than 75%.

Since patients with atherosclerosis of the carotid artery often suffer from coronary artery disease as well, their life expectancy is less than that of the normal population. Epidemiological studies comparing patients with TIAs with the normal population show a greatly increased probability of dying compared to the rate expected for a normal population in the first month after an initial TIA; after the first two years, the mortality remains steady, about 1½ times the expected rate. The 50% survival time is between seven and eight years, and the primary cause of death is cardiac disease.[122] Consequently, the challenge for the physician who cares for stroke-prone patients is not only to avoid the complications of cerebrovascular atherosclerosis but also to recognize and treat codeveloping coronary disease. Along these lines, it is important to note that Hertzer[113] has reported a statistically significant improvement in actuarial survival in postoperative carotid endarterectomy patients who incidentally underwent coronary artery bypass grafting.

New developments ● 1. A multicentered cooperative study by the Veterans Administration[123] is currently underway to determine the role of carotid endarterectomy in the treatment of asymptomatic carotid stenosis. The primary objective is to compare the incidence of TIAs, stroke, and death in previously asymptomatic patients with arteriographically documented internal carotid artery stenosis $\geqslant 50\%$ randomly allocated to carotid endarterectomy and aspirin therapy versus aspirin therapy alone. Ten VA medical centers are participating, and the study will be conducted over a period of eight years.

2. Proposals were submitted to the National Institute of Neurological and Communicative Disorders and Stroke (part of the NIH) in 1986 for approval of two prospective randomized studies. One led by Drs. Barnett and Peerless will compare medical versus surgical treatment of patients with symptomatic carotid disease. The other study by Dr. James Toole will evaluate medical versus surgical management of asymptomatic carotid patients.[124]

3. According to Warlow,[20] a randomized trial to determine the value of carotid endarterectomy after carotid TIA has begun in the United Kingdom, France, Holland, Germany and Italy.

4. In recognition of the fact that the benefit of carotid endarterectomy is closely related to safe conduct of the operation, leaders in vascular surgery[125,126] have stressed the importance of individual surgeons continuously monitoring their results in terms of volume of operations performed, perioperative stroke rate and mortality and long-term outcome. Hospitals should also maintain periodic audits by impartial but knowledgeable parties and establish and apply specific criteria for acceptable morbidity-mortality. Moore[125] emphasizes that it is inappropriate for an individual surgeon to quote someone else's results when apprising a patient of the risks of operation. He also states that only those surgeons with acceptable results (reflecting sound judgment in selection of patients and meticulous surgical techniques) are ultimately qualified to perform carotid endarterectomies.

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Medicine in 1995: A Forecast by the Experts

The future uncertainties that intertwine the fabric of American medicine confuse and disconcert us all. The critical questions that threaten physicians and hospitals will paralyze some individuals and subject them to a state of hopelessness and irresolution. Others will abandon medicine entirely. The majority will wait vigilantly and try to adapt on a quid pro quo basis as the medical scenery and rules change. The few will attempt to build a telescope through which they can glimpse the future and evolve a strategy that can be altered profitably as changes unfold. It is this last group that will survive most successfully.

Predicting future events is, of course, imprecise and hazardous at best. The lenses through which we look are astigmatic and hazy and provide us with a host of distortions. Nevertheless, the attempt at futurism must be made if we are to succeed in any enterprise. For this reason I reviewed the recent Arthur Andersen study, "The Future of Healthcare: Changes and Choices."[1] One advantage of this study is that it was not a survey limited to a narrow set of opinions of only one group of individuals such as physicians or politicians. Rather, it was an iterative survey conducted among health-care executives, trustees of hospitals and other patient-care institutions, physicians, nurses, payors, government bureaucrats and consumer representatives. Since this group is representative of the citizenry that will guide future policymaking of government and business, its findings are worth noting even though some of the predictions may be flawed. The survey is timely; it was completed in May of this year.

The survey was conducted among 1,600 panelists in two sessions. Each panelist received a questionnaire. The results of the first survey were fed back to the original panelists and a second questionnaire was submitted. Over 1,000 of the original 1,600 answered the second questionnaire. As expected, different societal subgroups had slightly different opinions about the future trends of medical care. I will present the consensus opinion.

The study encompassed several areas: national health-policy issues, access to health care, quality of health care, health-care payment systems, and choices available to American society.

National health-care policy • National health-care policy will be dictated most by the impact of the aging population in 1995. The future political influence of the elderly will increase along with their wealth and numbers. The elderly will be stratifed into at least two levels, the young and the old elderly, and different policies will probably be applied to each. Similarly, health-care access will vary between the affluent and the indigent elderly; the elderly will no longer be categorized as a homogeneous group. The government's response to the health-care system will be driven by budgetary rather than idealistic, philosophical or socialistic concerns. Most respondents to the questionnaire doubted that the government will be able to either adopt a national health policy or introduce a national health insurance plan.

Role of physicians • The role of physicians in the health-care system will continue to transform. The physician glut will be severe but the proposed excess will be moderated by the exclusion or limitation of licensing of foreign medical graduates and by an acceleration of the rate at which doctors retire entirely from practice because of dissatisfaction with the profession. Physicians will have to increasingly compete with nonphysician providers such as nurses, midwives, and physical therapists. Of course, physician income will decline and will be most severely

restricted in the fields of primary care and the referral specialties.

Physicians will, however, assume more prominence in management of the cost of patient care and in decisions regarding allocation or rationing of care. Similarly doctors will be incorporated into the governance and management of hospitals to a greater extent than they are today. They will also be the prime agents in establishment of criteria for quality control and in monitoring quality control; however, quality control will be shared with hospital trustees and chief executive officers.

The panel was sanguine about the malpractice crisis and felt that it would be resolved via a mixture of remedies: attorney contingency fees will be greatly curtailed or eliminated; providers will require

Physicians will assume more prominence in management of the cost of patient care and in decisions regarding allocation or rationing of care.

patients to sign arbitration agreements prior to receiving treatment, and state legislatures will set limits on the amount of payments for pain and suffering. Most importantly, the high expectancies of the health-care consumer for excellent results will be tempered by public education.

The mix of physicians will continue to be highly variable. In certain locales doctors will have to form alliances with other doctors, hospitals or entrepreneurial health-care institutions. These alliances will be distinct from HMOs and PPOs.

Quality of medical care ● Greater than 90% of the respondents to the study questionnaire assumed that criteria for and definitions of quality of medical care will be established and enforced by 1995. The respondents felt that the United States currently has the best system of health care in the world but they also agreed that standards of quality need to be set so that the cost - benefit ratios of further increases in health-care expense could be measured and justified. Doctors will provide the greatest input into establishment of health-care quality standards; they also will be relegated the major role in assuring that those standards are met — probably by means of peer review organizations that currently exist. Peer review will be the major mechanism of maintaining quality. Reviews by outside organizations such as that done by the Joint Commission on Hospitals will also be utilized. Mortality and morbidity data will be examined but health outcome status and patient satisfaction will be given little weight. None even considered the measurement of the economic benefit of health care as a measure of quality. It appears that the respondents expect good quality to continue to be defined as good paperwork.

The panelists philosophically agreed that the same level of quality should be available to all patients. The concept that the highest level of care should be provided to all was rejected; rather an adequate level should be available to all. Realistically they felt that financial considerations will obstruct the fulfillment of this goal. The respondents also realized that the health-care provider would sacrifice quality when economic viability was threatened.

Quality will be an important consideration and competition will be based on a consideration of quality and price rather than price alone. However, the definition of quality provided by the study remains nebulous and proposed solutions to grasping its meaning appear to have little chance of success.

Access to the health-care system ● Access to the system in 1995 will have the same limitations that exist today. Employers will continue to provide insurance coverage for their employees and the federal government will mandate that some minimal amount of health insurance be provided for all workers. Preventive medicine and wellness programs will be increasingly covered by health insurance.

Health care is expected to increase to at least 12% of the gross national product by 1995 and some rationing will be instituted to keep health care limited to this extent.

Rationing of health services will become a reality. This will pose major ethical problems for physicians but economic conditions will demand it. Health care is expected to increase to at least 12% of the gross national product by 1995 and some rationing will be instituted to keep health care limited to this extent. Age and ability to pay will be the major determinants of access to health care. Severe curtailment will be enforced in care for the terminally ill. The restriction of funding for new technology by insurance carriers and government will limit the introduction of expensive new technology and its exorbitant costs.

The medically indigent will continue to be squeezed out of the health-care system except for emergency surgery and some life-threatening conditions. Taxes will be levied at a greater rate to provide indigent medical services but the monies raised will not meet the requirements. A major share of the indigent burden will be laden upon the hospitals which will have to nearly double their indigent care budgets within the next eight years.

Health-care payment systems ● The government will continue to reduce its commitment to Medicare. DRGs will be sustained for at least another eight years. Medicare will reimburse primary care doctors on a capitation scheme; surgical specialists will be paid by a DRG scheme or by a fee schedule; hospital-based

doctors will have to derive their income from the hospital which will receive a lump sum payment for the cost of an illness. Medical specialists will probably be paid on either a DRG or a fee schedule system.

HMOs and PPOs will continue to expand. The economic viability and continued increase in the size and number of HMOs will depend upon the presence or absence of legislation that will coerce HMOs to enroll Medicare and indigent patients. If such requirements become law, then the HMOs industry will fail to grow.

Medicare beneficiaries and employees will be made responsible for a greater percentage of the cost of medical care by having to assume larger deductibles.

Future options ● The future success of participants in the health-care industry will become more dependent upon a new class of individuals — the comprehensive health-care manager. Managers will coordinate several activities: they will raise capital; integrate in-hospital with outpatient and outreach clinical activities; create alliances between physicians, other providers, and institutions; manage the risk of providing health care; enlarge community involvement in the local health-care system; organize and introduce better computer capabilities that can serve as better information retrieval systems and provide better medical decision making. The doctor will play a large part in these varied activities but he or she will share this role with hospital CEOs, trustees and board members. Better management will be the central theme of survival.

Conclusions ● Many of the predictions of this study are disappointingly obvious extrapolations of the current medical environment eight years into the future. Flickers of originality failed to flash across the pages of the report; but this lack of excitement is the natural result of a questionnaire survey.

The creative medical practitioner or medical practice researcher can be assured of one fact: surveys such as this, which record a consensus of the opinions of current experts, enjoy a consistency of misjudgment. They fail to accommodate upheavals in the economic cycle, political readjustments, or unforeseen technologic or sociologic changes. They cannot respect or predict the imaginative interplay of certain individuals or groups who will intellectually leap beyond the constraints of the current common wisdom and introduce an entire set of new complications or opportunities. Nevertheless, this study is useful. It identifies the current wisdom — a set opinion that we have suspected but never could document previously. We can now use this foundation of opinion as the platform upon which we can develop our future strategy.

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Jacques R. Caldwell, M.D.
Daytona Beach

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**CARDIZEM® (diltiazem HCl) is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents*

†See Warnings and Precautions.

Please see brief summary of prescribing information on the next page.



CARDIZEM® ANTIANGINAL PROTECTION PLUS SAFETY

diltiazem HCl/Marion

Usual maintenance dosage range: 180-360 mg/day

Brief Summary
Professional Use Information

CARDIZEM®
(diltiazem HCl) 30 mg, 60 mg, 90 mg, and 120 mg Tablets

CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
 Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%).

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 9/86

See complete Professional Use Information before prescribing

Rx
Cardizem® (diltiazem HCl)
☐ 60 mg ☐ 90 mg
☐ 120 mg
Sig: tid

References: **1.** *Schroeder JS: Mod Med 1982;50(Sept):94-116.* **2.** *Cahn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* **3.** *O'Rourke RA: Am J Cardiol 1985;56:34H-40H.* **4.** *McColl D, Wolsh RA, Frohlich ED, et al: Curr Probl Cardiol 1985;10(8):6-80.* **5.** *Frishman WH, Chorlap S, Goldberger J, et al: Am J Cardiol 1985;56:41H-46H.* **6.** *Shapiro W: Consultant 1984;24(Dec):150-159.* **7.** *O'Horo MJ, Khurmi NS, Bawles MJ, et al: Am J Cardiol 1984;54:477-481.* **8.** *Strauss WE, McIntyre KM, Parisi AF, et al: Am J Cardiol 1982;49:560-566.* **9.** *Feldman RL, Pepine CJ, Whittle J, et al: Am J Cardiol 1982;49:554-559.*

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News from DISTA about a new dosage form of cephalexin

ANNOUNCING NEW

Keflet®
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All the advantages of cephalexin in a convenient tablet form

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- May enhance patient compliance, particularly among the elderly
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NEW Keflet Tablets are available as:

250-mg Tablets



500-mg Tablets

Keflet is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

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Brief Summary. Consult the package literature for prescribing information. Indications and Usage: Keflet® Tablets (cephalexin, Dista) are indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus pneumoniae* and group A β-hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflet is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflet in the subsequent prevention of rheumatic fever are not available at present.)

Otitis media due to *S pneumoniae, Haemophilus influenzae*, staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli, P mirabilis*, and *Klebsiella* sp.

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose, the drug reached a maximum level of 4 μg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Reversible interstitial nephritis has been reported rarely. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

Pv 2211 DPP

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ZOVIRAX®
(acyclovir)
CAPSULES

Prevent genital herpes recurrences month after month with daily therapy.

(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)

Please see last page of this advertisement for brief summary of prescribing information.

ZOVIRAX®
(acyclovir)
CAPSULES

Help free your patients from recurrences.

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks—month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

Please see brief summary of prescribing information on next page.



Prevent recurrences month after month*

ZOVIRAX® (acyclovir) CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psycho-social difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

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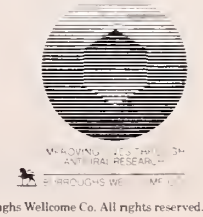
Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 ml/min/1.73 m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

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Many physicians would like to devote some time to their country in a local Army Reserve unit. We know that making a weekend commitment can be difficult for most physicians. So it is practical for the Army Reserve units to be flexible about time. It's worth discussing.

Incidentally, in addition to satisfying your own desire to serve your country, there are exceptional opportunities to do something totally different from a day-to-day routine. Opportunities to study new areas of medicine, meet new people in your specialty, and be a part of one of the world's most advanced medical teams.

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To find out about the benefits of serving with a nearby Army Reserve unit, we recommend you call our Army Medical Personnel Counselor.

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One, time. We know how tough it is for a busy physician to make weekend time commitments. So we offer flexible training programs that allow a physician to share some time with his or her country. We arrange a schedule to suit your requirements.

Two, the opportunity to explore other phases of medicine, to add a different kind of knowledge—the challenge of military health care. It's a flexibility which could prove to be both stimulating and rewarding, with the opportunity to participate in a variety of programs that can put you in contact with medical leaders from all over the country.

See how flexible we can be, call our Army Medical Personnel Counselor.

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☐ NOTES & NEWS

Four predoctoral interns learn it all at USF

Four University of South Florida interns are learning their trade the practical way while completing valuable training in the field of clinical psychology.

The interns, from as far away as Madrid, Spain, recently arrived at the Florida Mental Health Institute (FMHI) at USF. Richard B. Weinberg, M.D., director of psychology training, is exposing them to a wide variety of mental health programs within the state institute.

The interns are: Eva Palomo, from the University of Madrid; David Cotton, from the University of Alabama; and Marie McDonald and Ralph Dolente, both from the Florida Institute of Technology.

During their stay at USF, the interns are rotating among different FMHI departments, learning how the institute rehabilitates child molesters, applies daytime residential treatments and studies mental illness among the young and old. Minor rotations include the department of epidemiology, where doctors research mental health around the nation to determine areas where better care is needed.

Dr. Weinberg said FMHI has hosted eight interns since first establishing a program in 1984. For every position, the university receives up to 10 applications from predoctoral students interested in completing their required internships on the USF campus.

"We get the best here," Dr. Weinberg said. "And we as an institute benefit. Graduates go out and get good jobs. They carry the USF tag. Our reputation is being spread through our intern graduates."

The program's success is reflected by the fact that the American Psychological Association later this year will consider accrediting FMHI's predoctoral internship program two years ahead of schedule, Dr. Weinberg said.

Florida doctor to receive Loyola's Stritch Medal

Matthew J. Bulfin, M.D., of Lauderdale-by-the-Sea, will receive the 1987 Stritch Medal at the Loyola University Annual Award Dinner on Tuesday, November 24, at the Chicago Hilton and Towers.

A practicing obstetrician and gynecologist, Dr. Bulfin is a 1943 graduate of Loyola University's College of Arts and Sciences and a 1947 graduate of Loyola's Stritch School of Medicine; he was president of his medical class in the senior year. He is a diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American College of Obstetrics and Gynecology and a Fellow of the American College of Surgeons.

The Stritch Medal, first awarded in 1960, is awarded annually to a physician, teacher or medical researcher who displays professional competence, resourcefulness, loyalty, benevolence and dedication. It is named for the late Samuel Cardinal Stritch, Archbishop of Chicago who was a devoted friend of Loyola.

Dr. Bulfin was assistant clinical professor of obstetrics and gynecology at Stritch School of Medicine from 1957 to 1967, and chairman of the department of obstetrics and gynecology at Little Company of Mary Hospital, Evergreen Park, Ill., from 1960 to 1967. During this same period, he served as chairman of the Maternal and Infant Welfare Committee of the Suburban Cook County Hospitals and was a member of the Advisory Board of the State of Illinois Maternal and Perinatal Mortality Committee.

In the late sixties, Dr. Bulfin transferred his practice to Fort Lauderdale, joining the staff of Holy Cross Hospital where he served as chairman of its obstetrics-gynecology department from 1970 to 1974 and president of its medical staff in 1985. First elected in 1973, he is president of the American Association of Pro Life Obstetricians and Gynecologists and was chairman of the Eastern Mercy Hospital System Physicians Council in 1986.

Eye care for the elderly

Do you know an older person who needs medical eye care, but cannot afford it?

Ask them to call 1-800-222-EYES, the toll-free Helpline operated by the National Eye Care Project. Eligible callers will receive a referral to a nearby eye physician and surgeon (ophthalmologist) who has volunteered to provide care.

Every patient will be given a comprehensive medical eye examination for eye diseases and any needed treatment to protect vision. Services of the volunteer ophthalmologist are provided at no out-of-pocket cost to the patient. For this project, volunteer ophthalmologists are accepting Medicare and/or

other health insurance assignment as payment in full for their services. If the patient has no insurance coverage, medical eye care is provided without charge.

Although there is no financial qualification for the program, the emphasis of the project is to help those who may be without the means to pay — those who need the care the most.

• To be eligible, a person must be age 65 or older, a U.S. citizen, and no longer have access to an ophthalmologist he or she has seen in the past.

• This is not an eyeglasses program. The National Eye Care Project is designed to provide comprehensive medical eye examinations and treatment to prevent or control eye disease. Eyeglasses are not covered by the program.

• If hospitalization is needed, volunteer ophthalmologists may be able to work with the patient to obtain needed care. Hospital charges are not covered under this program or by the doctor.

• The National Eye Care Project is for needy older persons who do not have an ophthalmologist. It is not a second opinion program.

Older people suffer more than half of the blinding eye diseases in the U.S. — and about half of this blindness could be prevented. If you know someone who needs eye care, but cannot afford it, ask them to call 1-800-222-EYES today!

DEAN'S MESSAGE

The University of Miami School of Medicine celebrates its 35th anniversary

September 1987 marked the 35th anniversary of our school of medicine. From every standpoint, it came on the heels of the school's most productive academic year. The Liaison Committee for Medical Education, which visited the institution in February, granted full accreditation for the next seven years and described the school of medicine as "excellent."

Last year, our Biomedical Research Program experienced record growth, and we cautioned that it was unlikely to maintain this exceptional pace. However, 1986-87 was even more phenomenal. Sponsored support/research support exceeded the previous year's figures by $13 million. Moreover, clinical activities increased threefold over our own projections and the external perception of the University of Miami/Jackson Memorial Medical Center continued to improve dramatically.

Over the next several months, we will use the Dean's Page to provide the readers of *The Journal of the Florida Medical Association* with a brief review of each area of the school's mission. However, having just received the LCME's report, it is appropriate to succinctly summarize their observations. In part, it stated that the school "effectively melds the pursuit of scholarship to the remarkably efficient and compassionate care of a massive number of patients." The report also concluded that this "is done in an environment which emphasizes quality undergraduate education."

There was praise for the superb and dedicated basic science faculty who teach clinically relative science and the clinical faculty who teach medicine while immersed in patient care. The Liaison Committee noted that the faculty retained a flare for a firm grounding in the basic sciences despite the heavy burdens of its both public and private patient services. In conclusion, the report characterized the University of Miami School of Medicine "as most impressive in its successful pursuit of excellence in undergraduate medical education."

The major concerns of the Liaison Committee on Medical Education pertained to our combined Ph.D. to M.D. Program, which they perceived as excellent but which needed to meet the same clinical time standards as the regular four year program. A further concern was that the school have the highest standard for transfer applicants. Finally, the Committee expressed concern over the massive volume of indigent care being supervised by the clinical faculty and encouraged the state to provide more financial resources to the school's primary teaching hospital, Jackson Memorial, in order to maintain and improve our health care delivery system.

Obviously, the report of the LCME was extremely gratifying and the year 1986-87 was among the best ever experienced by our school. This achievement is due entirely to the strong commitment of faculty, administration and friends. We do, however, recognize that this success creates new challenges and responsibilities, especially as we celebrate an anniversary and look forward to the future.

Bernard J. Fogel, M.D.
Vice President for Medical Affairs
and Dean, School of Medicine
University of Miami

ENCORES!

Let Physicians Dispense Medication

The controversy of physician dispensing has been spotlighted by a bill recently introduced in the U.S. House of Representatives. An organized retail pharmacy lobby collaborating with Rep. Ron Wyden (D-

Oregon) is proposing severe federal restrictions of this physician practice that has traditionally and properly been a responsibility of the state licensing boards. Debate on the issue has been heated. Unfortunately, recent decisions and statements by legislators and medical leaders have been formulated more by hysteria and politics than rationale.

The "bottom-line mentality" of government, some large insurance companies and for-profit health care corporations is rapidly changing the environment in which medicine is practiced. While evolutionary changes in health care delivery should be encouraged and nurtured, they must also be objectively evaluated. Only then can effective and fair regulation in the best interest of the patients and society be legislated. Proactive involvement of the physician in the process of change is necessary to ensure quality patient care. The success of this involvement and the ability of the physician to acclimate to changes brought about by outside forces will determine the private care physician's survival. The resurgence of office medication dispensing, a traditional part of medicine, is only one of many ways physicians are adapting to this environment.

Office medication dispensing is a logical expansion of medical services that many physicians are integrating into their practices. It offers the patient convenience, better medical care and cost savings. It provides the physician with personal control of generic drug usage, improved patient compliance, better use of office personnel and an additional source of revenue to offset rising overhead. Computerized office dispensing systems further enhance patient care by providing accurate drug dosing, drug interaction analysis, patient allergy crosschecking and ready access to the patient's medication background.

Office medication dispensing offers a new level of convenience to patients. The patient avoids the time-consuming trip to the pharmacy and the frequent wait as the prescription is being filled. It decreases the chance of the pharmacist misinterpreting a written prescription and improves compliance by making sure the patient gets the right medication promptly. Medication counseling can be supplemented by the dispensary nurse, and this can be reinforced when the patient returns for refills. These additional office encounters for refills allow closer monitoring of the patient's clinical status and are appreciated by patients.

An equally important benefit to the patient is cost savings. These savings result from competitive pricing, appropriate use of generic medications and increased physician awareness of drug costs. Patients appreciate prescription prices that are comparable to or slightly lower than local chain pharmacies. Such pricing is consistent with guidelines in the American Medical Association (AMA) ethics manual, which state that "the physician may not exploit a patient in any way."[1] In our office, pricing based on the acquisition cost or average wholesale price of the drug plus a $2 to $4 handling fee offers savings for our patients and an additional source of office revenue. Cost-conscious patients quickly let us know if our prices are competitive.

Placing control of generic drug dispensing in the hands of the physician increases generic dispensing with resultant cost savings. Generics can be used with confidence since the physician, not the pharmacist, chooses when a generic is clinically appropriate and in the patient's best interest. The physician can also personally ensure the quality of generic medications, although much of this control and cost savings will be lost if drugs are supplied by repackaging companies instead of directly from wholesalers.

Increased physician awareness of drug costs creates additional savings. A major shortcoming of our present pharmacy dispensing system is the disassociation of the physician from the retail drug costs. Even though the physician is vaguely aware of these costs, it is the pharmacist who takes the heat for the $40 antibiotic or the $60 peptic ulcer medication. Office dispensing places the responsibility for high drug costs directly on the physician. He becomes acutely aware of these costs and modifies his prescribing habits to use less expensive, although equally effective, alternative treatments. The alternative could involve a generic substitute or a therapeutically equivalent drug that is less expensive.

Organized retail pharmacy groups have alleged that physicians dispensing will raise drug prices. The allegation was supported by anecdotal reports involving two physicians who had grossly overcharged for dispensed medications. No evidence was provided to substantiate widespread abuse, nor was there mention of a recent national study that demonstrated the common retail pharmacy practice of overcharging patients for generic drugs.[2] Unfair pricing by either physicians or pharmacists, besides being unethical, is not tolerated by today's cost-conscious patient. Overpricing is prevented by a competitive market where the patient is free to choose where he obtains his prescriptions. The Federal Trade Commission agrees with this principle and has come down firmly in favor of physician dispensing since it feels this supports competition and consumer choice. Federal Trade Commission Chairman Daniel Oliver, in testimony before the House Committee of Energy and Commerce, stated that a bill to prohibit physician dispensing "would be a prime example of unnecessary, heavy-handed anticonsumer governmental regulation."

Proponents of the legislation contend that office dispensing eliminates the "checks-and-balances" and counseling function that is provided by the pharmacist. This implies that the pharmacist is more knowlegeable about the patient's medication regimen and clinical status than the physician. This is not all

true. Admittedly, the pharmacist may have more overall knowledge about the 1,000 or more items that he dispenses. However, the physician is much more versed about the limited number of drugs that he uses frequently in his practice. He is also intimately aware of the patient's medical and emotional problems, which is essential when making decisions concerning dosing and drug interactions.

The pharmacist's present checks-and-balances function is being overplayed and can be more accurately and efficiently done by a computerized office dispensing system. Furthermore, the traditional role of the pharmacist as a counselor has significantly diminished as the corner drugstore has been replaced by the high-volume chain pharmacy. This diminished counseling role is documented by a recent Food and Drug Administration survey and is another deficiency of our present drug delivery system.[3] The survey indicates that physicians supply patient drug information more than twice as often as the pharmacist.

Organized pharmacy groups are using unsubstantiated, conjectural examples and ethical issues as a smoke screen to achieve their true goal, which is to protect one of the last monopolistic segments of health care. The $25 billion-a-year retail pharmacy industry must be subjected to the same scrutiny and competitive market forces that are being applied to other segments of health care.

The ethical considerations of physician dispensing are no different from those involved in fee-for-service medicine. Inherent in our fee-for-service system is the potential for conflict of interest. Practicing physicians address this situation any time they prescribe a service that they also provide to the patient. Although the system is not perfect, the vast majority of physicians respond ethically and honestly. They steadfastly act as the patient's advocate by placing the patient's interest and well-being before their own personal interests. Doing this depends not on the type of products and services that a physician provides, but on the physician's integrity and ethical standards. In addition, the AMA ethics manual clearly defines guidelines that must be followed to avoid possible conflict of interest. Patients must have "freedom of choice in selecting who will fill their prescription" The physician must "not exploit the patient in any way . . . " and must "disclose to the patient or referring colleagues his or her ownership interest in the facility or therapy."

The practice of physician dispensing is a tradition that offers the patient convenience and the potential for cost savings and better medical care. Computerized office dispensing systems offer several theoretical enhancements over traditional retail pharmacies and could soon become commonplace in primary care practices. The proposed law represents unnecessary and reactionary federal legislation in an area that is clearly the responsibility of state regulatory agencies. It presumes to address a problem that does not exist. The law would limit consumer choice, restrain competition and decrease incentives for physicians and pharmacists to offer better prices and services to their patients. There are many reasons to support the practice of physician dispensing, the most important of which is the continued ability of the primary care physician to ensure quality patient care.

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1. *"Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association"*, Chicago, 1986.
2. Bloom, B.S., Wierz, D.J., and Pauly, M.V.: Cost and Price of Comparable Branded and Generic Medications, JAMA 256:2523-2530, 1986
3. Morris, L.A., Grossman, R., and Barkdoll, G.L.: "A National Survey of Prescription Drug Information Provided to Patients", Food and Drug Administration, Rockville, Md., 1986.

Richard N. Marple, M.D.
Tulsa, Oklahoma

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Have Boards, Will Travel — Conspiracy of Silence?

Too often and for too long we physicians have been charged with engaging in a conspiracy of silence to protect each other. Never mind that the various state medical examining boards empowered to revoke our colleagues' licenses are composed mainly of physicians. Never mind that no malpractice case could ever get off the ground without a physician to offer an opinon that negligence was involved. Practicing physicians may not be entirely aware of the expanding industry of testifying physicians. So far there is no American Board of Testifying Physicians, but we may not be far from it, because many physicians are eligible for such a board.

A fringe benefit of having paid for two legal educations in my family is getting to look at law journals. Attorneys have the same kinds of journals we do — the prestigious, the theoretical, the humdrum, and the throwaway. They even have columnists who think they are occasionally amusing.

If you scan the pages of these law journals, glancing at such heartwarming titles as "Neurological injury to the newborn: Analysis of the medical evidence," "The hospital emergency room: Haven and hazard," and the ominous "Anesthesiology — the defenseless patient," you will see that the conspiracy of silence among physicians is mostly myth. The advertising pages list clear-cut offers by physicians and other practitioners to make themselves available to testify — in any way the plaintiffs' or defendants' attorneys want.

By grace of some examples:

Board Allergist and Internist *Available for analysis, review, report, testimony: will travel. Call Collect . . .*

Professional Medical Witnesses *Board-certified medical & surgical specialists in all fields of medicine. Available for evaluation, conferring and testifying on Medical Malpractice Litigation. Will travel. Call . . .*

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Among the more specialized is:

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More hopeful is:

Chiropractic Malpractice *For the plaintiff or defendant. Member of National and State association, professional societies. Twelve years experience. In* Who's Who in Chiropractic: *Case review . . .*

In a full-page ad, the American Chiropractic Association says that the doctor of chiropractic "can provide reliable expert witness testimony" and points out the areas of competence of chiropractic testimony, including "a chiropractor is competent in a personal injury action to interpret an x-ray photograph relating to injury or to the physical condition of the injured person, . . . the witness is qualified or familiar with the use of x-ray photographs, and the subject matter thereof relates to the profession or practice of chiropractic." The ad also promises, "The doctor of chiropractic can offer persuasive testimony in cases involving structural injury, 'whiplash,' soft tissue damage and post-traumatic complications." It concludes: "The chiropractor is competent to give expert testimony on the question of whether permanent injury was suffered according to interpretations under no-fault insurance laws."

An orthopedic corporation advertises: "Expert Medical Testimony for Medical Malpractice Liability & Compensation. For Orthopedic, Psychiatric (sic) and Emergency Room. For Plaintiff or Defendant . . . "

Consistent with modern American life, organizations quickly form to fill any perceived gaps. One such organization (with a toll-free number) provides "medical experts" for attorneys. Their letter to practicing attorneys boasts, "We have been directly responsible for helping plaintiffs' attorneys recover hundreds of millions of dollars for their clients in both medical malpractice and other personal injury cases . . . " They describe their medical experts as competent, credentialed, and board-certified. The group's medical director is an M.D., just like you and me.

Conspiracy of silence? Hardly. We have colleagues just aching to testify — any specialty, anywhere, any time, any side. Let's hope they are all dedicated to the truth.

Harvey N. Mandell, M.D.

Reprinted with permission from *Postgraduate Medicine*, Vol. 82, No. 5, October 1987.

Correction

A correction is necessary in "Book Reviews," *The Journal of the Florida Medical Association*, September 1987, page 711. In the fifth paragraph beginning, "Generally speaking . . . ," the second sentence should be: "The complaints that I have listed are minor ones as far as the accuracy and textural content is concerned." The book being reviewed is "Clinical Electrocardiography, A Primary Care Approach," by Ken Grauer, M.D., and R. Whitney Curry Jr., M.D. The reviewer is Mark V. Barrow, M.D.



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- *Legislative Drafting and Research*
- *Instructor of Risk Management, Malpractice and Compensation Systems Course at Harvard in cooperation with Harvard (Hospital) Risk Management Foundation*
- *Contributing columnist for* "Law Medicine Notes," *New England Journal of Medicine;* "Public Health and the Law," *American Journal of Public Health*

Medical liability and malpractice issues confront the practicing physician on a daily basis. This course is designed to provide physicians with a greater understanding of the underlying issues of legal decision in malpractice proceedings and appropriate approaches to risk management. It is specifically designed for Florida licensed physicians, although the content should be of interest to physicians licensed in other states. Designed as an introductory course of basic principles and practical applications, it will serve as a foundation for future courses which will be offered using the case studies approach in specific topic areas.

Program content and discussion will consist of the following elements: 1) medical malpractice in Florida—a current update and evaluation; 2) orientation to medical malpractice and risk management; 3) problems and pitfalls in malpractice for practitioners; 4) malpractice prevention and risk management; 5) principles of risk management; 6) hospital programs of risk management; and 7) practical applications of risk management systems in Florida.

TUITION: $175 per session (day)

Tuition includes admission to course sessions, coffee prior to session, refreshment breaks, luncheon and program materials. (A comprehensive syllabus and the text, *The Law of Medical Malpractice* by Joseph H. King, Jr., West Publishing Company, 1986)

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Book Review Editor — F. Norman Vickers, M.D.

The American Heart Association Cookbook and Dietitian's Food Favorites

The American Heart Association Cookbook, Fourth Edition, 542 pages, price: $16.95, David McKay Company, Inc., New York, 1984.

Dietitian's Food Favorites, 360 pages, price not stated, Cahners Publishing Company, Des Plaines, Illinios, 1985.

Mr. and Mrs. John Q. Public are bombarded daily by mountains of information about diet, cholesterol, unsaturated fats, calories, calcium and a host of nutritionally related topics. They swirl in a sea of data disseminated by physicians, health societies, hospitals, corn oil manufacturers, bran cereal creators, TV talk show hosts, aerobic exercise instructors, ladies magazines and newspapers. Some of the data is accurate, some is exaggerated and some is downright false. Where do Mr. and Mrs. JQP go for help in sorting out this avalanche of nutritional data as they attempt to develop sensible eating habits as advised by their personal physician?

A cookbook is a good starting point. Two recently surfaced on the editor's desk — *The American Heart Association Cookbook* (4th edition) and *Dietitian's Food Favorites*. Neither is hot off the press but their dietary messages continue to be crisp, fresh ideas that can make healthful eating a gourmet adventure.

Both cookbooks have some tantalizing recipes. The AHA's "Plaki Greek Fish with Vegetables" will dazzle the gourmet cook's dinner guests and family. It's also fun to read the book. The recipes are in bold type and set off with clever little pencil sketches. *Dietitian's Food Favorites* features culinary hits from around the country. Any Texan will vouch for the perennial success of "King Ranch Casserole." All the recipes in this latter volume include family size quantities and party-size quantities.

The AHA Cookbook would be an excellent gift for anyone opening his/her own kitchen. It includes a practical section on how to shop for food. It recommends making a shopping list, points out the cost of fresh foods versus frozen and canned, and unravels the mysteries of labels on food packaging. The very important discussion of dietary intake and its relationship to obesity, heart disease and hypertension is marred by its overuse of technical jargon such as LDL, CHD, and HDL. This section could have used the editorial skills of a Lois DeBakey. The Quantitative Nutritional Guidelines for different age groups is a gold mine of information but the miniscule print would tempt the average reader to skip it like so many superfluous footnotes in a text. However, these deficiencies are more than balanced by goodies such as a discussion of basic cooking techniques, creative use of herbs in recipes, and dining out in restaurants without breaking one's dietary commandments. The authors suggest calling restaurants to determine if they will meet one's dietary requirements. Be assertive; ask questions! Eat the French bread, skip the butter. There are always options that will permit one to enjoy an evening at an elegant restaurant even if he or she is on a strict dietary regimen.

Dietitian's Food Favorites is the American Dietetic Association's offering that encourages people to enjoy fine foods while remaining faithful to the basics of good nutrition. All recipes were carefully tested. Basic food groups were discussed clearly and concisely. A neat little chart tells the cook how much chicken to cook in order to get 2 cups of diced meat or how many crackers to crumble to get a cup of crumbs. Few cookbooks contain these handy little

pieces of information. The book's chief failure is the layout. It's like reading the back of a generic box of cereal. The various steps of the recipe are efficiently separated by stark black lines. The nutritional analyses of the sodium, potassium, calcium and vitamin content are lined off as on the back of a box of cornflakes. There are no drawings or colored photos. The few colored pages are used to separate the meat, vegetable, dessert and other sections and are easily missed. It is ironic that the dietitians who emphasized the importance of visual appeal in serving food would overlook the importance of visual appeal in presenting recipes.

Both are excellent cookbooks. However, the AHA presentation wins out because of its attractive layout and helpful suggestions for cooking, marketing and eating out as well as its abundance of gourmet quality recipes.

Elizabeth Vickers
Pensacola

- Elizabeth Vickers is a former nurse educator who is an occasional contributor to *The Journal*. She and her book-review editor husband have been reasonably successful in raising three children, nutritionally and otherwise, to young adulthood.

Kill as Few Patients as Possible

by Oscar London, M.D., W.B.D., 102 pages, price not stated, Ten Speed Spress, Berkeley, California 1987.

The best way to review this collection of irreverent essays by a Berkeley, California internist writing under the pseudonym of Oscar London is by book biopsy. His humorous essays appear regularly in the *San Francisco Chronicle*:

When All Else Fails,
Get a Five-Hour
Glucose Tolerance Test

Hypoglycemia is the last refuge of the neufatigue, nervousness, faintness, and excessive appetite — a veritable smorgasbord for the neurotic hungering for a physical diagnosis.

My patient — a pale, bearded lawyer — bursts into my office waving a magazine article he has just read. "This is it!" he shouts. "This is me!" He reminds me of Neville Chamberlain ecstatically waving a copy of the Munich Pact and proclaiming "Peace for our time."

"This is it!" repeats the patient. "This is me!"

"Let me guess," I say. "Hypoglycemia."

"Exactly!" he says, dumbfounded. "Why haven't you tested me for it before?"

"Because a five-hour glucose tolerance test hurts and it won't tell me what's wrong with you."

"I want it anyway."

Reluctantly, I agree to order a five-hour glucose tolerance test. I have found that nothing subdues a demanding patient more effectively than being stuck in the arm at least five times in five hours, *at his own insistence*. Along about the fourth hour my would-be hypoglycemic makes as if to swoon. An emergency Snickers is administrated.

In my experience, the results of a five-hour glucose tolerance test on a patient who requests it are invariably normal. The lawyer is heartbroken, of course. It's back to Valium, until he stumbles on an article about borderline adrenal insufficiency.

I don't mean to suggest that reactive hypoglycemia doesn't exist. I myself, if I miss lunch, begin to tremble and feel giddy about four o'clock. In my office refrigerator, next to my vials of tetanus toxoid and pneumococcal vaccine, I stock six unit-doses of Mars bars.

Physician, heal thyself.

F. Norman Vickers, M.D
Pensacola

- Dr. Vickers, an associate editor of *The Journal*, is in the private practice of gastroenterology.

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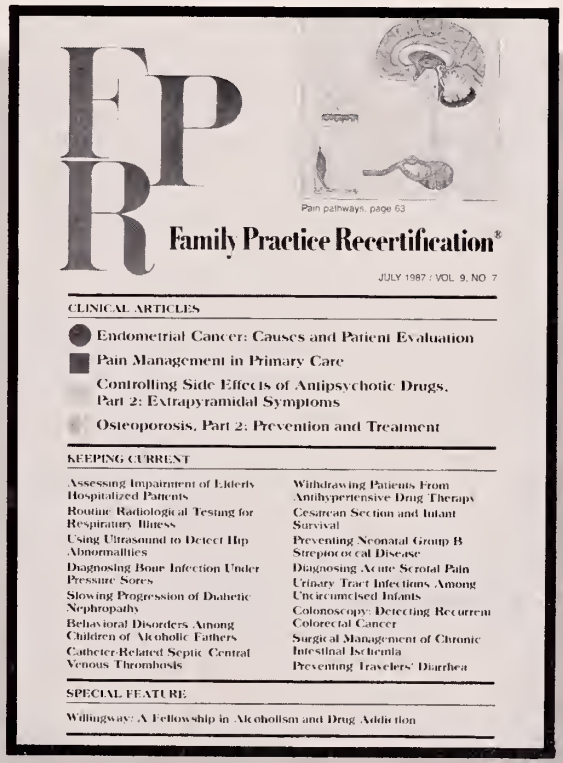
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FMA/A Convention Report

The Florida Medical Association Auxiliary, Inc., held its 60th Annual Meeting in Hollywood, Florida, September 16th through 19th at the Diplomat Hotel in conjunction with the FMA's Annual Meeting. President Susan Marks called the first session of the House of Delegates to order on Wednesday, September 16th, and the welcome was given by the President of Palm Beach County Auxiliary, Karen Philips. Dr. James B. Perry, FMA President, addressed the delegation and Betty Szewczyk, President of the American Medical Association Auxiliary, was introduced and stressed the importance of all doctors and their spouses being united today on the many issues that face them.

Reference committees on Bylaws and Finance met Thursday morning and following them, women from the auxiliary went into the FMA First House of Delegates. Dr. Perry had allotted time to recognize Mrs. Marks and other members of the auxiliary for their efforts in the special petition drive. We have already gathered the necessary 35,000 petitions which will be turned over to the Supreme Court for a ruling on the constitutionality of the amendment. If we can put this amendment (limiting awards to $100,000 for noneconomic damages) on the ballot, there is hope that we will receive relief from the real medical malpractice crisis that exists today in Florida. It is up to each of us to get the petitions signed!

The Annual Awards Luncheon, which is of great importance because Membership, AMA-ERF, International Health, Newsletter, Doctor's Day Scrapbook and FMF awards are given to the deserving counties, was held Thursday. The Peggy Wilcox Award was presented to Edie Epstein. Greetings from the Southern Medical Association Auxiliary were brought to the House of Delegates by the SMA/A President Virginia Hopper. She told about the SMA/A meeting which will be held in New Orleans and invited everyone. Reports were given by committee chairmen and county presidents.

On Friday morning the House of Delegates General Meeting and Installation of 1987-88 Officers by Betty Szewczyk, President of AMA/A was held. The Reference Committees made their reports and other county presidents gave their reports. There was a brief memorial service for all those auxilians who passed away this past year.

The Good Government Luncheon, sponsored by the FMA, the Auxiliary and FLAMPAC, was held on Friday with James K. Coyne, President of the American Tort Reform Association as the featured guest. Mr. Coyne was a dynamic speaker and he urged members to support FLAMPAC financially to help insure representation in our government which will be on medicine's side. Also he stressed the importance of supporting the candidates by volunteering time and talent in their campaigns. Mr. Coyne told how the American Tort Reform Association was formed and there are several groups, including the AMA and the Boy Scouts of America, who support him in his efforts to push for tort reform.

Preview 1987-1988, presided over by the newly elected President of the FMA/A, Betty Orr, is a new addition to the usual format of the Convention and was held on Friday afternoon and on Saturday morning. This portion of the meeting was intended to preview next year's activities and provide leadership for 1987-88 County Officers, Committee Chairmen and State Council/Committee Chairmen. Shirley Coletti, Director of PAR, was well received by her audience. She told of her association with First Lady Nancy Reagan and the respect she has for her because she had taken drug abuse as her project. Drug abuse continues to be an important focus in all our communities which we must continue to fight and the main force is education of the public. Dr. James White, the new President of the FMA, addressed the General Session. He told us what the FMA's goals were for this coming year and stressed how the auxiliary would be a vital part in those accomplishments.

Keep up the good work and get the petitions signed!

Mrs. Glenn (Carole) Hooper
Tampa

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

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References:
1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 62-69, 1984.

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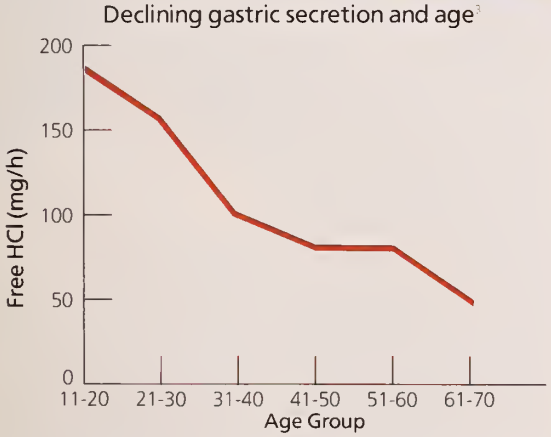
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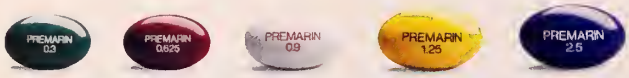
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0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

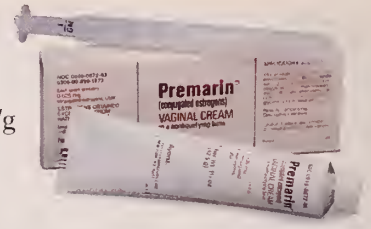
The appearance of these tablets is a trademark of Ayerst Laboratories.

For atrophic vaginitis

PREMARIN®
(conjugated estrogens)

Vaginal Cream

0.625 mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA
Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year This risk was independent of the other known risk factors for endometrial cancer These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4 5 to 13 9 times greater than in nonusers The risk appears to depend on both duration of treatment and on estrogen dose In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration, it therefore appears prudent to utilize such a regimen Close clinical surveillance of all women taking estrogens is important In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses
2 ESTROGENS SHOULD NOT BE USED DURING PREGNANCY
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare This risk has been estimated as not greater than 4 per 1,000 exposures Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix Although these changes are histologically benign, it is not known whether they are precursors of malignancy Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects One case-controlled study estimated a 4 7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion) Some of these exposures were very short and involved only a few days of treatment The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000 In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses If PREMARIN is used during pregnancy or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters Tablets are available in 0 3 mg, 0 625 mg, 0 9 mg, 1 25 mg, and 2 5 mg strengths of conjugated estrogens Cream is available as 0 625 mg conjugated estrogens per gram

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP) Moderate-to-severe *vasomotor* symptoms associated with the menopause (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions) Osteoporosis (abnormally low bone mass) Atrophic vaginitis Kraurosis vulvae Female castration
PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae
PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING)

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes Whether this will provide protection from endometrial carcinoma has not been clearly established There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens (See PRECAUTIONS) The choice of progestin and dosage may be important, product labeling should be reviewed to minimize possible adverse effects

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions 1 Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease 2 Known or suspected estrogen-dependent neoplasia 3 Known or suspected pregnancy (see Boxed Warning) 4 Undiagnosed abnormal genital bleeding 5 Active thrombophlebitis or thromboembolic disorders 6 A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy)

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning) However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens
Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement, it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use They should be used with caution in patients with cerebral vascular or coronary artery disease Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nontatal myocardial infarction, pulmonary embolism, and thrombophlebitis When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk
Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives For this reason, diabetic patients should be carefully observed Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients Oral contraceptives appear to be associated with an increased incidence of mental depression Patients with a history of depression should be carefully observed Pre-existing uterine leiomyomata may increase in size during estrogen use The pathologist should be advised of estrogen therapy when relevant specimens are submitted If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism
The following changes may be expected with larger doses of estrogen
a Increased sulfobromophthalein retention.
b Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3, increased norepinephrine-induced platelet aggregability
c Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay Free T_3 resin uptake is decreased, reflecting the elevated TBG, free T_4 concentration is unaltered
d Impaired glucose tolerance
e Decreased pregnanediol excretion
f Reduced response to metyrapone test
g Reduced serum folate concentration
h Increased serum triglyceride and phospholipid concentration
As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk
Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives breakthrough bleeding, spotting change in menstrual flow, dysmenorrhea, premenstrual-like syndrome, amenorrhea during and after treatment, increase in size of uterine fibromyomata, vaginal candidiasis, change in cervical erosion and in degree of cervical secretion, cystitis-like syndrome, tenderness, enlargement, secretion (of breasts), nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice, chloasma or melasma which may persist when drug is discontinued, erythema multiforme, erythema nodosum, hemorrhagic eruption, loss of scalp hair, hirsutism, steepening of corneal curvature, intolerance to contact lenses, headache, migraine, dizziness, mental depression, chorea, increase or decrease in weight, reduced carbohydrate tolerance, aggravation of porphyria, edema, changes in libido

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP
1 *Given cyclically for short-term use only* For treatment of moderate-to-severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0 3 mg to 1 25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals
2 *Given cyclically* Osteoporosis Female castration Osteoporosis —0 625 mg daily Administration should be cyclic (eg, three weeks on and one week off) Female castration—1 25 mg daily, cyclically Adjust upward or downward according to response of the patient For maintenance, adjust dosage to lowest level that will provide effective control
Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding

PREMARIN® Brand of conjugated estrogens Vaginal Cream
Given cyclically for short-term use only For treatment of atrophic vaginitis or kraurosis vulvae
The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible
Administration should be cyclic (eg, three weeks on and one week off)
Attempts to discontinue or taper medication should be made at three- to six-month intervals
Usual dosage range 2 g to 4 g daily, intravaginally, depending on the severity of the condition
Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding

References:
1. Lindsay R, Hart DM, Clark DM The minimum effective dose of estrogen for prevention of postmenopausal bone loss *Obstet Gynecol* 1984,63 759-763 **2.** Studd JWW Thom MH, Paterson MEL, et al The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N Paoletti R, Ambrus JL (eds) *The Menopause and Postmenopause* Lancaster, England, MTP Press Ltd, 1980, chap 13

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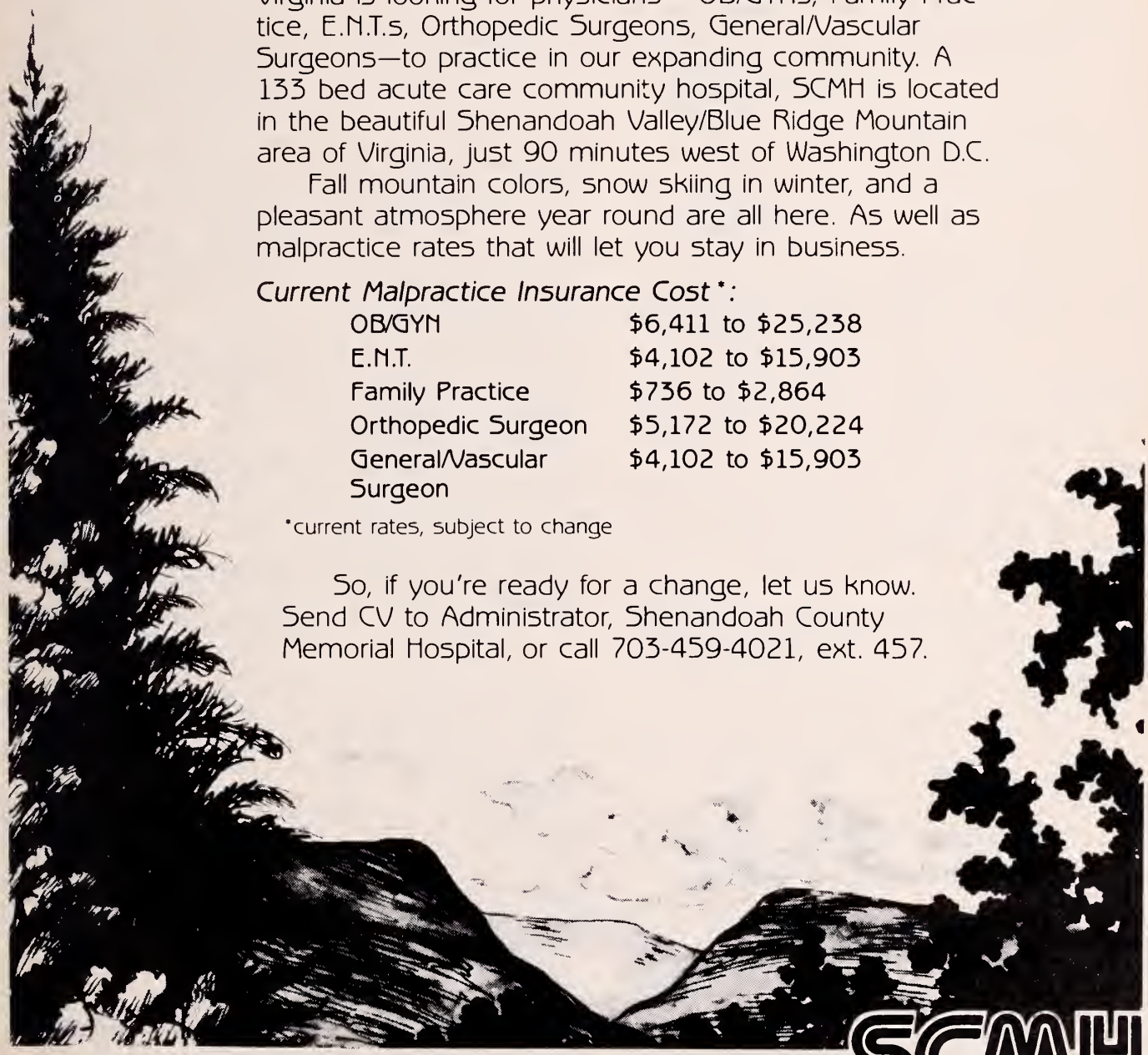
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Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

DECEMBER

Gastrointestinal and Hepatic Oncology, December 2-5, Lake Buena Vista, Contemporary Hotel. Contact: H. Worth Boyce Jr., M.D. (813) 974-2034.

Anxiety Disorders, December 3, Hyatt Regency, Tampa. Contact: Maureen McShane, M.D. (813) 254-1020.

Clinical Allergy & Immunology for the Practicing Physician, December 3-5, Buena Vista Palace, Lake Buena Vista. Contact: Richard F. Lockey, M.D., (813) 972-7631.

1987 Neuro-Opthalmology Course, December 3-5, Key Biscayne Hotel, Key Biscayne. Contact: Gaby Kressly (305) 326-6031.

Innovative and Controversial Strategies in Rehabilitation, December 3-6, Sheraton Bal Harbour, Bal Harbour. Contact: John H. Bowker, M.D. (305) 547-6716.

Diagnosis & Management of Respiratory Diseases, December 4-6, Boca Raton Hotel, Boca Raton. Contact: Karen DeBont, (800) 421-3756.

Risk Management Seminar, December 5, USF College of Med., Tampa. Contact: P.J. Bouis Jr., M.D. (813) 974-4296.

Basic Trauma Life Support Provider Course, December 5-6, USF College of Med., Tampa. Daniel Cavallaro, M.D. (813) 251-6911.

1987 FINA World Medical Congress, December 5-8, Justus Aquatic Center/Radisson Hotel, Orlando. Contact: Allen Richardson, M.D., (303) 578-4575.

Nonsexual Transmission of AIDS, December 6, Tampa. Contact: Barry Bercu, M.D. (813) 892-4233.

Emergencies in Internal Medicine, December 6-12, St. Thomas, Virgin Islands. Contact: Laurence B. Gardner, M.D. (305) 547-6716.

Special Topics in Diabetes Management, December 7, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Medical Risk Management, December 12, TBA, Jacksonville. Contact: Ronna Davis, P.O. Box 12099, Tallahassee, FL 32317. (904) 385-4935.

Risk Management Symposium, December 12-13, Peabody Orlando Hotel, Orlando. Contact: ASPRS, 233 N. Michigan Ave., #1900. Chicago, IL 60601.

The Dispensing Physician, December 18-19, Holiday Inn at University Mall, Pensacola. Contact: Dennis Burr 1-800-443-9218.

A Case Study Approach to Risk Management and Malpractice, December 18-19, Sheraton, Bal Harbour. Contact: Gloria Allington, University of Miami, P.O. Box 016960, Miami 33101. (305) 547-6716.

JANUARY

Chest Pain - The Great Mimic, January 9, Mt. Sinai Med. Ctr., Miami Beach. Contact: Esther Cohen, (305) 534-2916.

Advanced Vitreoretinal Surgery Course, January 14-16, Sarasota. Contact: Miguel Arcacha, M.D. (813) 952-0900.

Workshop in Clinical Hypnosis, January 14-17, Las Palmas Hotel, Orlando. Contact: Charles B. Mutter, M.D. (305) 547-2000.

33rd Annual Cardiovascular Seminar, January 15-16, St. Petersburg Hilton, St. Petersburg. Contact: Melissa S. Crater, (813) 867-5000.

Advances in Neurology, January 17-23, South Seas Plantation, Captiva Island, Ft. Myers. Contact: Millie F. Walden (904) 374-6058.

Magnetic Resonance Imaging, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Lipo Injection Technique, January 19, 1988, University of Miami, Miami. Contact: Larry D. Garland, M.D. (305) 547-4477.

20th Annual Postgraduate Seminar in Pediatric and Adult Urology, January 21-23, Doral Beach Hotel, Miami Beach. Contact: Charles Lynn, M.D. (305) 547-6596.

USF Contact Lens Course, January 22-23, Lincoln Hotel, Tampa. Contact: Charles Slonim, M.D. (813) 974-4360.

Drug Therapies in Diabetes Management, January 23, Hyatt Regency, Tampa. Contact: John Malone, M.D. (813) 974-4360.

5th Annual Doctor's Hospital Winter Seminar, December 23-30, Vail, Colorado. Contact: George T. Venis, M.D. (305) 856-6121.

Problem Oriented Approach to Vitreous Surgery, January 25-27, Biscayne Bay Marriott, Key Biscayne. Contact: Karl Olsen, M.D., University of Miami, Dept. of Ophthalmology (305) 326-6031.

Magnetic Resonance Imaging, January 25-28, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

20th Post Convention Seminar, January 25-28, Acapulco Princess Hotel, Acapulco. Contact: Charles Lynne, M.D. (305) 547-6596.

12th Annual Halifax Pastoral Care Institute, January 28-30, Halifax Hospital, Daytona Beach. Contact: Chaplain James Smith, (904) 254-4138.

2nd Annual Conference on Ethical Issues in Health Care, Orlando Marriott Hotel. Contact: Grace Wagner (904) 392-6428.

Arrhythmias: Interpretation, Diagnosis and Management, January 29-30, Bahia Mar Hotel, Ft. Lauderdale. Contact: Deborah Wilderson 1-800-421-3756.

Vail Conference in Anesthesiology, January 30-February 6, Vail, Colorado. Contact: Brian Craythorne, M.D. (305) 547-6411.

FEBRUARY

13th Annual Review and Recent Practical Advances in Pathology, January 31 through February 5, Fountainbleu Hotel, Miami Beach. Contact: Marie Valdes-Dapena, M.D. (305) 549-6437.

Current Concepts in Cardiovascular Disease, February 1-5, Buena Vista Palace Hotel, Orlando. Contact: Clarence Shub, M.D. (507) 284-2511.

Vail Symposium in Intensive Care, February 6-13, Vail, Colorado. Contact: Brian Craythorne, M.D. (305) 547-6411.

Current Clinical Concepts in Reproductive Endocrinology and Perinatology, February 8-10, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

20th Miami Winter Symposium, February 8-12, Hyatt Regency, Miami. Contact: W.J. Whelan, M.D., University of Miami, Dept. of Biochemistry (305) 547-6265.

Risk Factors for the Development of Skin Cancer and its Treatment, February 9, University of Miami, Miami. Contact: Larry D. Garland, M.D. (305) 547-4477.

Cardiology at Walt Disney World, February 11-14, Contemporary Resort Hotel, Lake Buena Vista. Contact: Scott Greenwood, M.D. (305) 843-1330.

14th Annual Fred J. Woods Lecture Series, February 12-13, St. Josephs Hospital, Tampa. Contact: Ralph Jensen, M.D. (813) 877-3682.

Alcohol and Substance Abuse, Miami Airport Hotel, Miami. Contact: Raphael S. Good, M.D. (305) 549-7661.

Magnetic Resonance Imaging, February 15-19, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Conference on the Beach, February 15-20, Holiday Inn Surfside, Daytona Beach. Contact: William G. Tomson, M.D. (904) 254-4167.

Special Topics in Diabetes Management, February 16, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Reproductive Organs Abnormalities Symposium, February 17-20, Vail, Colorado. Contact: James Ingram, M.D. (813) 974-2088.

Sarasota Vitreoretinal Update Course, February 18-20, Colony Beach Resort, Longboat Key. Contact: James Kingham, M.D. (813) 921-5335.

10th Annual Pulmonary Winter Course, February 18-21, Contemporary Hotel, Lake Buena Vista. Contact: Richard T. Doggett (904) 743-2933.

Pediatrics for the Practitioner: Update on Pulmonary Diseases, Sheraton Tampa East, Tampa. Contact: Herbert H. Pomerance, M.D. (813) 974-4214.

Dementia: Current Research and Clinical Aspects, Radisson Plaza Hotel, Orlando. Contact: Eric Pfeiffer, M.D. (813) 974-4355.

Health Care for the Elderly, February 19-20, Radisson Hotel, Orlando. Contact: Eric Pfeiffer, M.D., USF Med. Center (813) 974-4355.

Pediatric Dermatology CME Tour, February 19-March 7, India. Contact: Mr. Frank Martin 1-800-243-5030

Eyelid Surgery: A Basic Course for the Practicing Physician, February 20, USF College of Med., Tampa. Contact: J. Justin Older, M.D. (813) 971-3846.

Radiology in Seville, February 20-27, Seville, Spain. Contact: Lucy R. Kelley (305) 674-2681.

Neuroradiology Seminar, Radisson Plaza Hotel, Orlando. Contact: Rick D. Mace (305) 897-1944

Breast and Thyroid Surgery: Current Controversies and Management, February 21-23, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

15th Annual Symposium in Pediatric Nephrology, February 21-25, Sheraton Bal Harbour Hotel, Miami Beach. Contact: Pearl Seidler (305) 549-6726.

Internal Medicine 1988, February 21-26, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bocles, M.D. (305) 547-6063.

Magnetic Resonance Imaging, February 22-28, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Basic Trauma Life Support Provider Course, USF College of Med., Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

February Course in Electrocardiography, February 29-March 2, Marriott Hotel, Boca Raton. Contact: Jules Constant, M.D. Cardiac Study Fund, Box 114, Hiler Branch, Buffalo, NY 14223 (716) 836-5172.

MARCH

20th Teaching Conference in Clinical Cardiology, March 2-5, Sheraton Bal Harbour, Bal Harbour. Contact: Michael S. Gordon, M.D., Ph.D., University of Miami (305) 547-6716.

Mid-Winter Seminar in OB/GYN, March 3-5, Don CeSar Resort, St. Petersburg. Contact: James Ingram, M.D. (813) 974-2088.

9th Annual Advances in Clinical Medicine, Park Suites Hotel, Orlando. Contact: Michael Kessler, M.D. 1-800-334-6578.

9th Annual Mammoth Mountain Emergency Medicine Ski Conference, March 6-11, Mammoth Lakes, Calif. Contact: Medical Conferences, Inc. 1-800-457-2777.

Cardiovascular and Diabetic Therapy, March 7-9, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

Wound Dressing/Retinoic Acid March 8, Univ. of Miami, Miami. Contact: Larry D. Garland, M.D., P.O. Box 016960, Miami, FL 33101

2nd Annual Oncology Conference, Peabody Hotel, Orlando. Contact: Wendy J. Henry (305) 897-1600.

Selected Issues in Adolescence, March 11, Harbour Island Hotel, Tampa. Contact: Herbert Pomerance, M.D. (813) 974-4214.

Breast Disease Update & Seminar, March 16-18, The Hilton, Lake Buena Vista. Contact: Esther Cohen, M.D. (305) 674-2311.

Team Management in Patient Care, March 21-22, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Pediatric Goldcoast Conference, March 21-23, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

10th Annual Family Practice Review, March 21-25, Holiday Inn Surfside, Clearwater Beach. Contact: Frances Adams (813) 893-6156.

AIDS: Defining the Process, March 24-26, Building TBA, Daytona Beach. Contact: Halifax Medical Center, Educational Services (904) 254-4169

Cancer Conference, March 25-26, Daytona Hilton, Daytona Beach. Contact: Nancy Drane, R.N. (904) 254-4212.

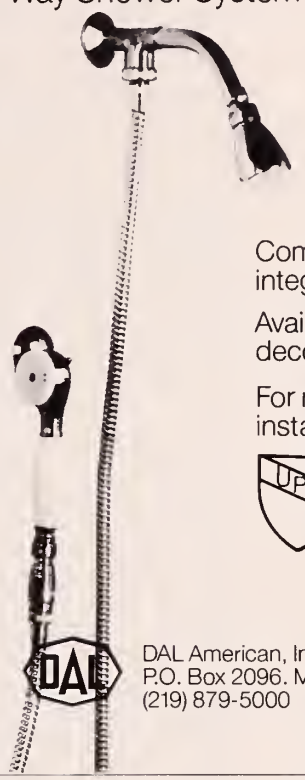
9th Annual Advances in Clinical Medicine, Park Suites Hotel, Orlando. Contact: Michael Kessler, M.D. 1-800-334-6578.

Board Review Course in Geriatrics, March 28 - April 1, Radisson Plaza Hotel, Orlando. Contact: Eric Pfeiffer, M.D. (813) 974-4355.

Estrogen Replacement Therapy in Pre- and Post Menopausal Females, March 29, Hyatt Regency, Tampa. Contact: Maureen McShane, M.D. (813) 254-1020.

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SURGEON, THORACIC-VASCULAR (no open heart) to join solo practitioner on West Coast of Florida, St. Petersburg, Florida. Please send CV, photo and letter to: Florida Medical Association, Inc., P. O. Box 2411, C-1444, Jacksonville, FL 32203.

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BC/BE FAMILY PRACTITIONER or General Internist. Needed immediately and next year by long established family practice group near Kennedy Space Center. Competitive salary. Early partnership. Large clinic facility and state-of-art local hospital. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1445, Jacksonville, FL 32203.

INTERNIST TO JOIN solo practice in growing suburban Jacksonville community. Good family area. Send CV to P.O. Box 2706, Orange Park, FL 32067-2706.

EXCELLENT OPPORTUNITY for Primary Care Physician to join an established clnic in rural Eastern Kansas. Developing area with 3 large lakes, hiking, fishing, hunting. Good schools, low crime area, easy access to big cities. For details contact Dr. Mitra, 222 Garetson, Burlington, KS 66839, 316-364-2114.

INCREDIBLE OPPORTUNITY: East Orlando, Unique medical complex - two miles from Martin Marietta and Westinghouse, U.C.F. and Research Park. No MD competition. Seeking Pediatrics, Ophthalmology, E.N.T., Urology, Gastroenterology, Rheumatology. Financial assistance available. Contact: H. Orizondo, (305) 299-8420.

IMMEDIATE OPENING for BE/BC Radiologist in Central Florida. Florida license required. Must be experienced in all modalities including interventional & MRI. Send CV to R. Nash, M.D., 735 W. SR 434, Suite I, Longwood, FL 32750.

ORLANDO: Full-time opportunities available for physicians board prepared in Family Practice, Internal Medicine or Emergency Medicine to staff a new Urgi-Care facility in the Orlando area. Excellent compensation plus malpractice insurance provided. Respond with CV to: Cheree Richards, EMSA, 100 N.W. 70th Ave., Plantation, FL 33317 or call collect at (305) 584-1000.

PRACTICE OPPORTUNTIES for family practice or emergency physicians in ambulatory care centers. Competitive hourly fee with ecomonic incentives. Association with hospital E.D. Contact: Robert Schiffer, MRMC, P. O. Box 6000, Ocala, FL 32678. Call (904) 351-7600.

GENERAL INTERNIST, RHEUMATOLOGIST, NON-INVASIVE CARDIOLOGIST, PEDIATRIC SURGEON, AND OBSTETRICS & GYNECOLOGY: 40 physician multi-specialty Group in W. Palm Beach, FL seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 2 years. Send CV to Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 N. Olive Ave., W. Palm Beach, FL 33401.

EMERGENCY MEDICAL GROUP, a progressive, physician-owned organization is seeking Full and Part-time Board certified/eligible and Family Practice physicians for openings in Southeast Florida. Competitive salary, paid malpractice insurance, benefits and attractive scheduling. Send CV to Emergency Medical Group, 1400 NW 12th Ave., Miami, FL 33136.

INTERNIST OR NONINVASIVE CARDIOLOGIST: Southwest North Carolina, Family-oriented, semirural tourist town 1-2 hours from Asheville and Atlanta. Supported by less than 100 bed hospital, 3-county drawing area of 70K. Outdoor amenities: hunting/fishing/camping/skiing/etc. Compensation: 1-year guarantee/office space/set-up support. Contact Bob, Tyler & Co., 9040 Roswell Rd., Atlanta, GA 30350. Call 404-641-6411.

SHENANDOAH VALLEY of Virginia: Shenandoah County Memorial Hospital of Woodstock, Va. is looking for physicians-OB/GYNs, Family Practice, E.N.T.s., Orthopedic Surgeons, General/Vascular Surgeons - to practice in our expanding community. A 133 bed acute care community hospital, SCMH is located in the beautiful Shenandoah Valley/Blue Ridge Mountain area of Virginia, just 90 minutes west of Washington, D.C. High income potential and LOW malpractice rates (See our display ad p. 899 for a complete list of rates) Call the Office of Administration at 703/459-4021, ext. 457, or send CV to: Administrator, Shenandoah County Memorial Hospital, P.O. Box 508, Woodstock, Virginia 22664.

FT. LAUDERDALE: Florida licensed physician wanted part-time to perform clinical exams in busy screening center. Flexible hours. Call Michele 305-742-3500.

ENT - Develop solo practice in semirural, family-oriented, southern Virginia town. Supported by 260 bed hospital, 20+ primary care physicians with three county drawing area. Outdoor amenities such as hunting and fishing; 2 hours from 6 major medical schools. Strong compensation/benefits package including office setup, overhead contribution and malpractice. Contact Bobby, Tyler & Company, 9040 Roswell Road, Atlanta, GA 30350. Call 404-641-6411.

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IMMEDIATE OPENING BC/BE clinical adult Neurologist with experience in EEG, EMG & VEP. To join established busy Neurological Group - East Coast of Florida. Competitive Base Salary, incentive benefits with early partnership available. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1442, Jacksonville, FL 32203.

GENERAL SURGEON: Board Certified General Surgeon needed to join expanding 85 Physician multi-specialty medical center in Los Angeles and Orange counties. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1436, Jacksonville, FL 32203.

FAMILY PRACTITIONER or INTERNIST - Central Florida. Immediate availability in a Medical Walk-In Clinic practicing outpatient and in-patient care. Join a General Surgeon, Internist and Dermatologist in a very progressive, busy clinic. Generous compensation package with excellent future. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1435, Jacksonville, FL 32203.

BC/BE INTERNIST to join solo Internist in rapidly growing river community in northeast Florida. Partnership potential in two years. Send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1432, Jacksonville, FL 32203.

GENERAL SURGERY: Opportunities available in CA, OR & WA. Excellent compensation/income potential including salary guarantees and reasonable malpractice rates in communities offering high quality of life. Contact PROSEARCH, 305 NE 102nd Ave, Portland, OR 97220-4199, phone (503) 256-2070.

BC/BE FAMILY PRACTITIONER to join six physician department in a 38 member multispecialty group located on eastern Florida's treasure coast. Excellent salary, benefits and growth potential within this progressive organization. Send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1441, Jacksonville, FL 32203.

FAMILY PHYSICIAN: BC or BE for West Palm Beach practice. FL license necessary. Opportunity for future partnership. Call: (305) 967-0234.

BOARD CERTIFIED GENERAL SURGEON, as associate, private practice in Orlando. Send CV, references, photo to Box C-1366, P.O. Box 2411, Jacksonville, FL 32203.

MEDICAL PRACTICE opportunities available throughout the midwest and western United States. 30 attractive locations to choose from in metropolitan and rural areas. All with excellent salary and benefits. We will match your personal and professional needs with the right practice opportunity. Contact a member of the Health Manpower Placement Program at The Center for Rural Health Services, Policy and Research, 501 Columbia Road; Grand Forks, North Dakota 58201; or call 701-777-3262 collect. We make the intelligent match!

FAMILY PRACTICE - Blue Ridge Mts. of North Carolina. Board Certified FP needed to join 4 group practice. 12 miles from HCA managed hospital. Guaranteed salary incentive program. Send CV to Bakersville Clinic, P.O. Box 27, Bakersville, N.C. 28705 or call R. Duncan (704) 688-2104.

FAMILY PRACTICE - Semi-Retired or just want a slower pace. Take over a rural satellite clinic of a larger center, located in the Blue Ridge Mountains of N.C. Send CV to Bakersville Medical Clinic, P.O. Box 27, Bakersville, N.C. 28705, or call R. Duncan (704) 688-2104.

WEST PALM BEACH area, Florida. BC/BE pediatrician to join well established group of 4 pediatricians. Competitive salary and benefits. Dr. Moshe Adler, 1718 North Federal Highway, Lake Worth, FL 33460.

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WINTERHAVEN, Clermont, Vero Beach, Tavernier Keys: Director positions available for BC/BE Emergency Physicians. Excellent growth opportunities with established national emergency medicine group. Competitive compensation, attractive benefit package. Professional liability insurance procured on your behalf. Please call or submit CV to: Beth Barlow, Coast Emergency Services, Inc., (800) 328-1038 in U.S. or (800) 432-3093 in FL; 2200 W. Commercial Blvd. Ste. 203, Ft. Lauderdale, FL 33309.

FAMILY PRACTICE, RURAL COLORADO — BC/BE Family Practitioner to join three FPs in growing multi-specialty group. Excellent opportunity for person interested in rural living, mountain recreation, health care delivery for medically underserved populations. Send CV to Michael Bloom, 204 Carson Ave., Alamosa, CO 81101. 303-589-5161.

FAMILY PRACTIONER /PRIMARY CARE PHYSICIAN/GENERAL INTERNIST. Well established 30 member multispecialty group needs 2 full-time board certified or eligible physicians. Fully equipped facility- laboratory, x-ray, CT scan, physical therapy, pharmacy. Administrative services provided. Fringe benefits. Excellent practice opportunity in one of the fastest growing communities in Florida, located on beautiful southwest coast. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1423, Jacksonville, FL 32203.

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OB/GYN - California, Central San Joaquin Valley, County Sponsored, Sixteen (16) Physician Multi-Specialty Group Practice with three (3) satellite locations, committed to high quality care, is looking for a board certified/eligible OB/GYN to provide ambulatory, delivery, and surgical services. The position provides a comprehensive benefit package and includes malpractice insurance coverage. Consider a semi-rural lifestyle with cultural amenities and easy access to metropolitan areas, the Sierra Nevada Mountains, and the Pacific Ocean. Salary $98,112 - 103,116 annually. Send CV to: Michael L. MacLean, M.D., Hillman Health Center, 1062 South "K" Street, Tulare, CA 93274, (209) 688-2015. Equal Opportunity Employer.

ORTHOPEDICS, NEUROLOGISTS AND NEUROSURGEONS needed immediately and for 1988 for groups and multispecialty clinics. Opportunities throughout America. The Lewis Group, 1227 N. Valley Mills, Suite 200, Waco, TX 76710, 817-776-4121.

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CENTRAL AND COASTAL FLORIDA/NATIONWIDE OPPORTUNITIES Available now for BC/BE physicians also accepting 88 residents. Complete confidentiality, please respond by sending CV or telephone: Frank B. Lane, M.D., Medical Director, MCA, 5121 Ehrlich Road, Suite 107A, Tampa, FL 33624, 813-968-3878.

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HOLBROOK, ARIZONA a community of 7000 1½ hours from Flagstaff, has an excellent opportunity for a BE family practitioner doing limited obstetrics. Practice assistance package includes first year salary guarantee, free rent, and malpractice insurance. Contact PROSEARCH, 305 NE 102nd Avenue, Portland, OR 97220. 503-256-2070.

TIRED OF HMOs? Conduct your specialty or primary care practice in a traditional setting in a growing community south of Ocala. Demand for all specialties exceeds supply (AMA market profile available). The new Mockingbird Hill Professional Center is now open with lease/purchase option. Opportunity now exists for custom interior design. Lab and x-ray on-site and private ambulatory care center provides a referral base. Only 10 min. drive to HCA hospital. For information call or write Carol Roberts, Care-1, Inc., 1805 S.E. Lake Weir Ave., Ocala, FL 32671 or (904) 351-0789.

FAMILY PRACTICE: Opportunity to join three board certified F.P.s in a rapidly growing practice at the Beach. Excellent community to live and grow. Next to a large metro area. Practice is strong in wellness, preventive and psychosocial medicine. Salary negotiable with opportunity to buy in. Contact: North Beach Family Practice, Attn: Dr. R. D. Gottula, 100 Royal Palm Dr., Atlantic Beach, FL 32233. Or call (904) 241-5107.

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VASCULAR/GENERAL SURGEON: Board Certified General Surgeon with two-year Vascular Surgery Fellowship. Seeking private practice affiliation with busy group. Florida license; native of South Florida. Available July 1988. Write: P.O. Box 2411, Box C-1411, Jacksonville, FL 32203.

GENERAL SURGEON, 54 years old, Board Ceretified Florida licensed. Seeking relocation. Consider Solo, Group, clinic, HMO, assisting, some general practice, etc. Write Florida Medical Association, Inc., P. O. Box 2411, C-1426, Jacksonville, FL 32203.

HUSBAND AND WIFE TEAM interested in practicing office GYN and general medicine only. Husband Board Certified and recertified in OB/GYN and presently active in large OB/GYN group practice. Wife actively practicing general medicine, mostly geriatric in Veterans Administration Out Patient Clinic. Both in possession of Florida license. Reply: 2525 13th St. N.W., Canton, Ohio 44708.

RHEUMATOLOGIST and INTERNIST, M.D.'s, FL licensed, certified ABIM, Boston trained. Seek practice opportunity in coastal Florida. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1430, Jacksonville, FL 32203.

PEDIATRICIAN: Personable & versatile. U.S. Grad. University trained. 20 years experience. Allergy trained. Board Certified. Desires challenging association in FL. Interesting practice more important than income. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1438, Jacksonville, FL 32203.

FLORIDA LICENCED M.D. with 10 years extensive experience as hospital physician seeks full time employment with established HMO/Walk-in Clinic/M.D. Group/or Family Practice, Medical Treatment Center, Health Department/or similar. Available now or by December. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1439, Jacksonville, FL 32203.

FAMILY MEDICINE — Florida licensed. Seeking Locum Tenens work. Call 305-878-6608.

B/E INTERNIST, retired, looking for position, association or share office in South Palm Beach County. 305-734-6046.

GENERAL SURGEON, University Trained, Trauma Center experience. Desires position in Coastal area. Solo or HMO preferred. Available July '88. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1446, Jacksonville, FL 32203.

TO PURCHASE: Internal medicine or family practice. Internist, extensive practice experience, wishes purchase (or partnership) of well established private practice in Broward or Palm Beach County. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1431, Jacksonville, FL 32203 or telephone (305) 492-0818.

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INTERNAL MEDICINE PRACTICE FOR SALE: 80 miles south Disney World, in central Florida. Retiring 28 years. Holter Monitor, Fiberoptics, complete lab, etc. Will introduce. Prefer Cardiologist or gastroenterologist. P.O. Box 2411, C-1418, Jacksonville, FL 32203.

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- **Predictable dose response[4]**
- **Diuresis completed hours faster than with furosemide after oral dosing[5]**
- **Better GI absorption[6,7]**
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As with all loop diuretics, excessive doses of BUMEX can lead to profound diuresis with water and electrolyte depletion, including hypokalemia, so serum electrolytes should be monitored.

References: 1. Flamenbaum W: *Am J Cardiol 57*(2):3BA-43A, 1986. **2.** Brater DC, Fax WR, Chennavasin P: *J Clin Pharmacol 21*:599-603, 1981. **3.** Iber FL, Baum RA: *J Clin Pharmacol 21*:697-700, 1981. **4.** Henning R, Lundvall O: *Eur J Clin Pharmacol 6*:224-227, 1973. **5.** Physicians' Desk Reference, 40th ed. Oradell, NJ, Medical Economics Company, 1986, pp. 939, 1480. **6.** Pentikainen PJ, *et al: Br J Clin Pharmacol 4*:39-44, 1977. **7.** *Lasix, A Review*. Somerville, NJ, Hoechst-Roussel Pharmaceuticals, Inc., 1980.

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INDICATIONS AND USAGE: Edema associated with congestive heart failure, hepatic and renal disease, including the nephrotic syndrome.
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In cats, dogs and guinea pigs, Bumex has been shown to produce ototoxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ototoxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially at high doses.
Patients allergic to sulfonamides may show hypersensitivity to Bumex.
PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets.
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Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions.
Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions.
Drugs with nephrotoxic potential and bumetanide should not be administered simultaneously.
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Laboratory abnormalities reported are hyperuricemia, azotemia, hyperglycemia, increased serum creatinine, hypochloremia, hypokalemia, hyponatremia, and variations in CO_2 content, bicarbonate, phosphorus and calcium. Although manifestations of the pharmacologic action of Bumex, these conditions may become more pronounced by intensive therapy.
Diuresis induced by Bumex may also rarely be accompanied by changes in LDH, total serum bilirubin, serum proteins, SGOT, SGPT, alkaline phosphatase, cholesterol, creatinine clearance, deviations in hemoglobin, prothrombin time, hematocrit, platelet counts and differential counts. Increases in urinary glucose and urinary protein have also been seen.
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Oral Administration: The usual total daily dosage is 0.5 to 2.0 mg and in most patients is given as a single dose.
Parenteral Administration: Administer to patients (IV or IM) with GI absorption problem or who cannot take oral. The usual initial dose is 0.5 to 1 mg given over 1 to 2 minutes. If insufficient response, a second or third dose may be given at 2 to 3 hour intervals up to a maximum of 10 mg a day.
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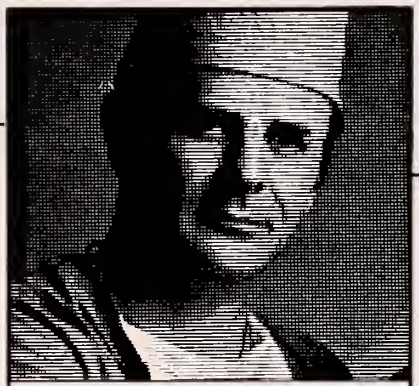
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Update on the PLI Issue



Since our last visit, we have had some very significant developments in the legislative arena. Our efforts to get MICA passed in the upcoming Special Session of the Legislature will fall short. We need 61 votes in the House of Representatives and were able to muster 40. Our efforts to succeed were diluted when the Academic Task Force report came out with a negative recommendation on MICA. We had an actuarial study on the Task Force recommendations and it showed that there would be no reduction in premiums if this were passed into law.

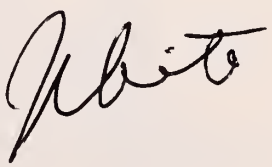
Representative Sam Bell then revised the Task Force recommendations by decreasing the caps on general damages to $100,000 - $200,000 on those cases going to arbitration. This, coupled with removing central nervous system-damaged babies from the tort system and redefining trauma cases to gross negligence, would produce a savings of 20 percent over current premiums.

While this bill is by no means perfect, it is a substantial step in the right direction. The FMA Board of Governors approved it in principle at a special meeting in Atlanta on December 6, 1987. We are still in close communication with Representative Bell, hopeful of making some further improvements in the bill.

We are planning a meeting with all county medical society Presidents and Executive Directors in the next two to three weeks to fully explain the bill, pointing out both its strengths and weaknesses.

We are not abandoning MICA, but will keep it on deck so that when the political climate is right, we will once again place it before our legislators. We know that all our members are anxious to get the PLI problem behind us so that we can concentrate our legislative efforts on problems with mandatory assignment, MAAC fees and the PRO.

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Medicine: An Uncertain Future

Dr. Robert Petersdorf, President of the American Association of Medical Colleges, appeared early this month at the interim meeting of the AMA in Atlanta to bring the dismal news that the numbers of medical school applicants have been steadily declining. He implored physicians to reverse the trend by talking more to young people about the virtues of medicine as a profession amidst the problems that have been rocking it. That may be too tall an order to fill.

The deans at the medical schools naturally are concerned that the pool of medical applicants is drying up. Where before there were four applicants for every spot in medical school, the ratio had dropped to less than two to one. That obviously will dilute the quality of the applicants, although the good medical schools will continue to attract the best and the brightest. The worst scenario is that if the current trend were to continue, some medical schools may be forced to close their doors just like some dental schools already did. Considering the tight financial situation in some medical schools today, that is not all a far-fetched possibility.

But how do we even start to lure back our young people to consider medicine as a career? How do we fire their imaginations and convince them that medicine is still the best and the noblest of the professions? We can start by highlighting the good things about our profession. Many of us, given the choice, would not want to do anything else except practice medicine. Despite the mounting problems, medicine remains one of the most rewarding careers professionally and personally. Healing the sick and comforting the afflicted may sound like an old cliche, but there is still nothing that can match the profound satisfaction and the sense of fulfillment that go with what physicians do everyday of their lives. The challenge to work hard and serve people becomes more exciting at a time when physicians are equipped with better drugs, better surgical techniques, and sophisticated diagnostic advances. For those interested in research, there is a wide vista of opportunities particularly in the fields of immunology, cancer, atherosclerosis, and pharmacotherapy. The financial rewards are not bad either despite higher overheads and declining third-party reimbursements. And as a group, physicians are always the most esteemed and the best respected among all professionals from year to year.

Can we, indeed, reverse the trend and attract more young people to pursue medicine? Is Dr. Petersdorf's plea to us a realistic call or a pipe dream? What about the less appealing side of medicine?

Cataloguing the negative aspects of medicine, of course, is easy, particularly in the gloom-and-doom atmosphere prevading the practice of medicine today. Physicians, first of all, are finding less fulfillment and satisfaction with their loss of professional autonomy. With increasing third party intrusion, more and more physicians are getting frustrated at their inability to make decisions on their patients, and things are not getting any better. The government, in particular, has many physicians in chains with its onerous imposition of cookbook medicine and strangulating regulations. AMA President Dr. William S. Hotchkiss was echoing the sentiment of many physicians when he said that the loss of autonomy of physicians poses the single greatest threat to the health of medicine today.

Along with the erosion of their autonomy, physicians today remain tormented by the threats of an escalating malpractice problem. Across the country, the problem has become critical, particulary in Florida where exorbitant insurance premiums have forced many physicians to curb or limit services in trauma care, obstetrics, and neruosurgery. The little fun left practicing medicine is gone in this kind of atmosphere.

As sophisticated as medicine has become, it has also changed in many respects, and not alway for the better. Alutrism is almost gone, replaced by crass commercialization. Increasing competition has driven medicine into the marketplace, and it is now common to speak of medical services as commodities, of patients as consumers, and of physicians as providers. This loss of professionalism has hurt the image of medicine.

On top of all these burdens, the process of acquiring a medical education and then pursuing postgraduate training is a long and arduous one. Tuition fees keep going up, with the average medical student owing an average debt of $35,000 after leaving medical school. In the meantime, other challenging opportunities are opening up in such fields as computers, engineering, and business, all requiring much less time but providing good financial rewards.

The crunching realities of current medical practice leave physicians uncertain about how to recruit your men and women into medicine. Most of us, like Dr. Petersdorf, are concerned about the future of

medicine, and we owe it to future generations to maintain and strengthen our tradition of service and accomplishments. It will be a hard job. We can talk to young people but we ought to be honest, pointing out the strengths and the virtues of our profession and balancing them against the array of problems that we have. On this basis, they should be able to make intelligent decisions. I am an optimist by heart, but if things do not change, I am afraid that Dr. Petersdorf and the rest of us may be whistling in the dark.

R. G. Lacsamana, M.D.
Editor

A Fresh Wind Blowing

Over the past several months I have appeared on two radio talk shows, held a news conference, and given many informal talks concerning the malpractice crisis. I have come away from those conferences with a change in my attitude which existed several years ago. I have now been in practice for eight years and throughout most of that time have been involved with the malpractice crisis. I have gone to Tallahassee several times, spoken out on every opportunity on the malpractice crisis, helped to collect petitions for a constitutional amendment and will continue to do those things for as long as it is required. However, until recently, I must admit that I always felt that physicians were facing a tremendous struggle because I did not think the public was on our side. I felt that in the early 1980's the public was very distrustful of physicians, thought we made too much money and sided with those forces against us. I think at that time that was a true assessment of the situation.

I feel the hostility and bitterness started in the 1950's and was brought to a head in the 1960's and 1970's and was still very apparent in the 1980's. Many people felt that physicians had turned away from them, had forgotten the patients' best interests and instead were controlled and driven by other interests. Whether or not that was true is a question that will be debated for many years and is still open for historians to answer in the years to come.

It is certainly true that the age of technology in the 1950's-60's led to a division between physicians and patients. Incomes for physicians have risen since World War II and as a result of specialization we appeared to become impersonal to many patients. In retrospect that was probably inevitable. No longer could a family physician provide all the care and give a patient that best possible medical care that he or she deserved. The family physician had to consult with specialists, had to order what was becoming increasingly expensive tests and in the process the interpersonal relationships deteriorated. As I said, I think this was probably inevitable and perhaps medicine could have done a better job of blunting the change and have avoided much of the criticism that arose in those years. In any event, in the early 1980's, that distrust and criticism of physicians was very vocal and alive. I certainly felt it in 1984 when many physicians across the state of Florida were speaking out for malpractice reform. Often times it was a very chilling reception and one that often bordered on hostility. Many people seemed to feel that the medical profession was threatening to take away their rights in the courtroom and that we were doing it for selfish and economic reasons.

However, over the past year, I have come to change my mind. At the present time I feel that the public in Florida is now on the side of the physicians. I have come to this opinion through the radio shows and newspaper conferences in which I have been involved. The radio shows have been open to questions by the public and it has been amazing to me that over 80 percent of the people who call in have been favorable to the physicians and to our position. It has been a remarkable change and one which I did not really think was present until the past few months. This is probably a result of several factors. One of the most important factors is that we have realized we dropped the ball in the 1960's and 1970's, and regardless of whether or not it was intentional, medicine did leave the impression that it was becoming an impersonal profession and was not satistying the emotional and personal needs of the patients whom it served. We were reactionary in those years and were sometimes closed ranks about any criticism to this end. Often as not, physicians were defensive when criticized and would often lash back with an attack of our own. I think that has definitely changed in the 1980's. I feel physicians are willing to admit that there were mistakes made and we need to rectify those mistakes. I think that this has been a sincere effort on the part of physicians. More important, I think it has been perceived by the citizens of the state that it is a sincere effort.

Another factor which I think has helped the public to come to support our cause is that the trial attorneys have made many of the same mistakes over the past few years that medicine made over the past

several decades. While the trial attorneys have made a great public furor about how effectively they police their ranks and how ineffective doctors have been, this has all be shown to be a smokescreen as far as the public is concerned with lawyers showing up at every scene of tragedy soliciting clients. Of cource this has largely come about because the Supreme Court had stated that it is legal for attorneys to advertise. The Florida Bar has said that they have restrictions on advertising and they have tried to make it a professional and dignified approach. They have failed in this. While it may not be completey the fault of the Florida Bar in that they do have constraints proposed upon them by higher legal authorities, they attorneys now have much of the same distrust that used to be directed to the physicians. Moreover, the Florida Bar has seemed to be somewhat impotent in stopping the practices which they say are illegal even under the more liberal guidelines as spelled out by the Supreme Court. The public cannot forget the horde of attorneys who descended on the families of a recent bus accident in which exceptional children were involved. When the public no longer trusts what the trial attorneys are telling them about their efforts to clean up their own house, they no longer will accept the attorney's reasons for the malpractice crisis.

Lastly, I think another factor which has helped to bring the public into the camp of physicians is that the public is sophisticated and intelligent enough to see that you cannot separate what is happening with the malpractice situation and the whole economic picture. Certainly the national debt and the recent collapse of the stock market have been people much more aware of the strained economic conditions of our country. They can also read the paper and see huge malpractice verdicts which make no sense to them either for the amount of the money or for the reasons for them in many cases. While I previously did not think that the average citizen thought very much about the huge amounts given for malpractice awards, I have been disabused of that notion. On a recent radio show I mentioned a huge malpractice award given in New York for $48 million. The people who called in to comment were simply aghast that no matter if there was a medical mistake, $48 million was simply a totally unbelievable figure.

I am now much more optimistic than I was one year ago. I feel that the legislature must at least take some action in addressing the malpractice crisis. I also think that if they do not take appropriate action and it has to go before the public for any constitutional amendment, medicine will prevail. All the polls have indicated this. The polls may be off in that they indicate that about 68 percent of the people favor limiting malpractice awards and doing something about the malpractice situation in Florida. I think it may even be more than that.

However, before physicians go off with the idea that they are going to be received by everyone with magnanimous hoops and hollers, let me hasten to add that there are still some who are very vocal in their criticism of physicians and of our attempt to change the present system of tort law into a system of contract law. I have had those callers also and on a factual basis they have not been able to win their case. However, they do become very emotional and accuse physicians of being brainwashed by the AMA, the FMA, and of trying to take away the rights of people. I have made it my rule that when I address these people or when they confront me with their questions or their accusations, I will simply give them the figures that are available to all and let the listeners make the decision on who is right and who is wrong.

I feel that medicine has come back from the brink of losing the public confidence to the position where we have now regained at least some credibility in the eyes of the public. If we continue on our present track and approach, I think we will continue to gain that respect and strengthen our position.

H. Frank Farmer, M.D., Ph.D.
New Smyrna Beach

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The New Greatest Lie in the World

"We realize that's a problem, and we're working to correct it." This phrase may soon replace "The check is in the mail," presently the greatest lie in the world, as the most frequently used phrase by managed care executives.

During the three and one half years International Medical Centers (IMC - HMO) existed in Palm Beach County, both phrases were heard with nauseating regularity. In fact, they were uttered so often many people began to believe they were true. As everyone knows, these promising phrases did not fool physicians, and while it took the government some time to listen to the facts, IMC is no longer with us. With IMC now only a bad memory, how do these pronouncements affect practicing physicians in 1988?

For the past six months, my office has served as a primary care provider for an IPA - HMO. After repeated bureaucratic bungling, overutilization of our services, and unrealistic expectations on the part of the patients, we gave the required 90-day notice that we were leaving. Following receipt of our letter by the HMO, we received a phone call from the provider representative who wanted to talk with us about the reasons for our departure. The meeting was cordial, involving a free exchange of information. Whether the meeting helped him, I'm not sure, but it was highly informative for us: it revealed the sorry state of affairs to which managed care plans have evolved.

The first half hour of the meeting was an enthusiastic presentation of the HMO's recent and planned expansion, along with names of prominent (?) venture capitalists interested in investing big dollars in their HMO for the chance to earn even bigger dollars. I assume we were supposed to be suitably impressed with the fact that there were potentially large profits to be made in buying, selling, merging, and acquiring HMOs. Eventually, we were able to shift the discussion away from the business of HMOs to the mundane problems physicians and their office staffs were having with the HMO administrative bureaucracy. The usual answer to each identified problem was, you guessed it, "We realize that's a problem, and we're working to correct it." As we had more patients in our panel than any other doctor in the plan in Palm Beach County, we were asked to stay in the program for six months or so to give them a chance to correct the deficiencies. We refused. Enough was enough.

Thanks to the eye-opening experience with IMC, it has been obvious to me for years that the real name of the HMO game is mergers and acquisitions, profits and losses. The businessmen owning and running HMOs use slick marketing to collect premium dollars (be it from private concerns or the federal government), guaranteeing themselves a good salary, a company car and an expense account. Their goal is to expand and sell out, if possible, or go public and pocket a hefty profit. While HMOs are perceived to exist to provide health care, this function is merely a front for the real function of capital formation. It is quite obvious that an HMO needs its primary care doctors to deliver the medical care they are promising to subscribers. Managed care executives urge doctors to join the plan or risk losing their patients, and succeed in getting many conscientious albeit mildly paranoid physicians to sign contracts and accept a small capitation fee to ration out medical care under strict utilization control. The HMO is free to spend its time trying to make a profit. As long as the plans are able to provide a list of doctors for their subscribers to call, the administrators fulfill their promise. Is it any wonder that the HMO representative tried to persuade us to stay in their plan? Without primary care physicians acting as "case managers" (read — decrease utilization), the HMO cannot deliver the care they are promising and making themselves a profit in the process.

I believe that the HMO movement as we know it in 1987 has peaked, even though new HMOs are constantly being formed. In a recent issue of American Medical News, the following headlines appeared over three separate articles: "HMO chain's stock drops after high medical costs bared;" "Half of HMOs in Milwaukee losing money;" "HMOs lose big in Texas, Minnesota." If HMOs themselves can't make money, it's a sure bet that the physicians providing care aren't being compensated well either. Recently three HMOs in Florida besides IMC have failed, leaving large debts in their wake. IMC departed owing providers over $100 million for care that was given to their patients and by law it was obligated to pay. When HMOs go under, the executives draw their salary until the final day, while the owners take out everything they can. Guess who's left high and dry? Of course, the providers who have been delivering medical care in good faith until the very end.

In the case of IMC, hundreds if not thousands of doctors cared for IMC patients in emergency situations for which they will never be compensated. While the HMO goes bankrupt, the insurance commissioner sells its assets but not its liabilities, and the owner flees the country, presumably with his retirement fund safe in a foreign bank.

Twenty years ago the health care pie was divided among hospitals, doctors, pharmacists and other health care personnel. Today, the pie may be slightly larger, while the provider's slices have become smaller. A new slice has been created for the business of health care. Does this shift of dollars actually improve the quality of health care? I doubt it. We've created a new class of well-paid executives who plan to oversee the business of health care delivery and subjugate physicians to the role of low-paid employees.

"We realize that's a problem, and we're working to correct it" will be heard with increasing frequency over the next few years. I believe that problems exist in the HMO system for which there are no solutions. The demise of the HMO system will occur when patients and physicians discover that the system is the problem and the problem is uncorrectable.

Lee A. Fischer, M.D.
West Palm Beach

Editor's Note: Dr. Fischer is so right in his observations. Another great lie heard more and more often is this line from certain physicians to their patients: "This procedure will cost you absolutely nothing." (Translation: Medicare will take care of my big bill.)

Other physicians, I am sure, have their favorite lies, and are invited to send their observations to The Journal.

The Rural Generalist

Never before has economics had such a dramatic impact on the practice of medicine. Because of this, more and more physicians feel compelled to align themselves with larger groups in order to compete and capture or maintain their "market share" of patient care. The common goal must be to provide both cost-effective and high-quality patient care and hopefully maintain a sense of professional satisfaction.

The need for "strength in numbers" has created a unique marriage between large highly specialized physician groups and smaller, often rural, primary care generalists (family practitioners, pediatricians, obstetricians). Historically, the attraction of each group to the other has been far from natural and often strained. Long-term success will depend on each understanding the other.

Physicians are a diverse group of individuals. The fact is that a doctor's choice of specialty and practice location is not accidental. Therefore, it should be obvious that rural generalists have characteristics somewhat different from urban subspecialists. It is certainly worthwhile to examine the major differences.

The Nature of the Beast

I. Outlying generalists like to work independently.

They have neither the capability nor the desire to be "all things to all people" but thrive on the challenge of treating a variety of problems. They represent the gateway for the patient's total health care. By providing care and coordinating consultations they quickly develop a sense of control, a sense that can easily be threatened in today's environment.

The reality of Medicare criteria, PPOs, PROs, HMOs, all impose someone's cookbook onto private practice. Prohibitive liability insurance premiums force many generalists to reduce their services (i.e., OB care).

The final straw can be a perceived threat to control of their patient's health care from large multispecialty groups.

II. Referral physicians are strongly bound to their local community.

Identifying the priorities of rural generalists is simple. Like other physicians their strongest commitment is to the patient. Beyond this, the generalist looks to colleagues in his local area for support and they to him. Local hospital services are next in priority.

The mutual success of the generalists, local specialists and hospital depends on this priority sequence. The regional consultant is the final priority and should complement, not duplicate, services. Those services that can be provided by competent local specialists should not be actively sought by regional consultants for fear of breaking down this priority sequence and with it the morale of the referral medical community. Every effort must be made to return patients to their local generalist.

III. Referral physicians are paranoid about large impersonal groups.

The "good old boy" image is alive and well in many rural communities. Because of exposure to all family members over a period of time the generalist builds personal as well as professional bonds with his patients. Patients in multispecialty clinics tend to be shifted from doctor to doctor according to the nature of their complaints. Such a system makes a personal touch harder to achieve. The generalist is aware of this and fears that his patients may be swallowed up, once again a loss of his sense of control.

IV. Referral physicians are generally good doctors.

The misconception that rural care is inferior to urban care, and generalist's care is inferior to subspecialist's care, can destroy the referral system quickly. The fact is that rural generalists

are generally well-educated and current in their knowledge of diagnosis and treatment. The care they provide is limited, but not in its quality. Their practices are typically very large, busy and successful.

The Don'ts:

1. Don't belittle the generalist with "one-up-manship." To imply that the patient finally got to good medical care by coming to the regional referral center is degrading to the referral physician. To be sure he will find out. To be sure you will not get other referrals.
2. Don't be afraid to do nothing. An unnecessary zebra hunt is often expensive and unrewarding. It is fine to confirm the referral doctor's plans if indeed they are appropriate.
3. Don't initiate multiple referrals unless it is an emergency. Remember, the patient was referred to you, not your entire group.
4. Don't forget to notify the referral doctor about No. 3 as soon as possible.
5. Don't delay consultation because you are "too busy." The referral doctor is probably as busy as you are. If he asks for a consult in a specified time all efforts should be made to accommodate him.
6. Don't forget to send his patient back. Feedback, whether written or oral, should be timely.
7. Don't forget the uniqueness of isolation. It is natural for the consultant to become a little angry when seeing occasional referrals with functional complaints. You must remember, however, that the referring generalist has seen the same patient with the same complaint a number of times. These desperation referrals are frustrating but nonetheless valid. Your reassurance to the patient may seem like a waste of time but it is often what is needed to allow these patients to comfortably live with their functional illness without more tests and treatments.
8. Finally, and most importantly, don't do anything to disrupt the referral physician's commitment to his local community.

Paul A. McLeod, M.D.
Milton

Chiropractor Questions Editorial

In the September edition of The Journal, you raised several questions in an editorial on chiropractic that you urge can come only from the scientific community.

I trust that group includes chiropractors such as myself. Or, indeed, are our problems insurmountable? I'll presume not. Let me offer some responses to your "is it asking too much" inquiries:

It is asking too much to require chiropractors to explain the scientific foundation of their calling over and over again;

It is asking too much to require chiropractors to explain the scope of their practices and to justify them over and over again;

It is asking too much to set up peer review groups from knowledgeable people in the sciences to monitor what chiropractic care is all about unless the knowledgeable include Doctors of Chiropractic.

Sooner or later, you are going to have to stipulate that overwhelming evidence has already been offered to sustain the chiropractic principle and scope.

Let's make it sooner and get on with the process of working together in the interest of the public need to receive the best health care we can all offer.

J.K. Hendricks Sr., D.C.
Winter Haven

Editor's Note: Begging the question never serves the cause of science nor the interests of patients. Faulty logic also never leads to the right answer.

The Florida Suing Virus Has Spread to Pittsburgh

After considerable thought and study, I have come to the conclusion that the malpractice problem in Florida is caused by a suing virus. A virus explains the fact that malpractice started in a heavily populated area, Miami, and spread through the remainder of Florida over a relatively short period of time. The malpractice virus resulted in an increase in malpractice insurance which also spread from the metropolitan Miami area to the remaining cities in Florida and recently into the rural areas. As a result of the malpractice virus, the malpractice fees in the state have increased a thousand percent over the last ten years.

The suing virus is carried by residents of the Miami area, especially the Miami attorneys. Miami attorneys cause the spread of the virus by direct contact with other people and other attorneys. The virus is similar to AIDS and is named ARC virus (Attorney Related Complex). Unfortunately for the doctors of Pittsburgh Children's Hospital, they operated on a Miami child who needed three liver transplants. The child's surgery was not successful and the child died.

The unfortunate fact is that the mother of the child and her attorney carry the ARC virus. The mother, who instead of being grateful for the tremendous effort that the Pittsburgh doctors and the rest of the country made toward her child, is making motions toward suing the Pittsburgh Children's Hospital. She received $450,000 in donations to pay for the surgery, instead she intends to sue the hospital. These events show indisputable evidence that the ARC virus has spread directly to Pittsburgh via a Miami carrier. This is a very unfortunate turn of events.

In the future, doctors outside Florida may refuse to treat a Florida resident for fear that he or she might be exposed to the Florida suing virus. Once these doctors' insurance companies realize they are caring for a high-risk Florida patient, their malpractice insurance will take a drastic increase. Doctors in other parts of the country may have an unfounded fear that they will contract the virus if they care for Florida patients and will refuse to take care of them.

It is my firm opinion that if the suing virus is not eradicated from Florida, the health care of the entire nation may be in jeopardy.

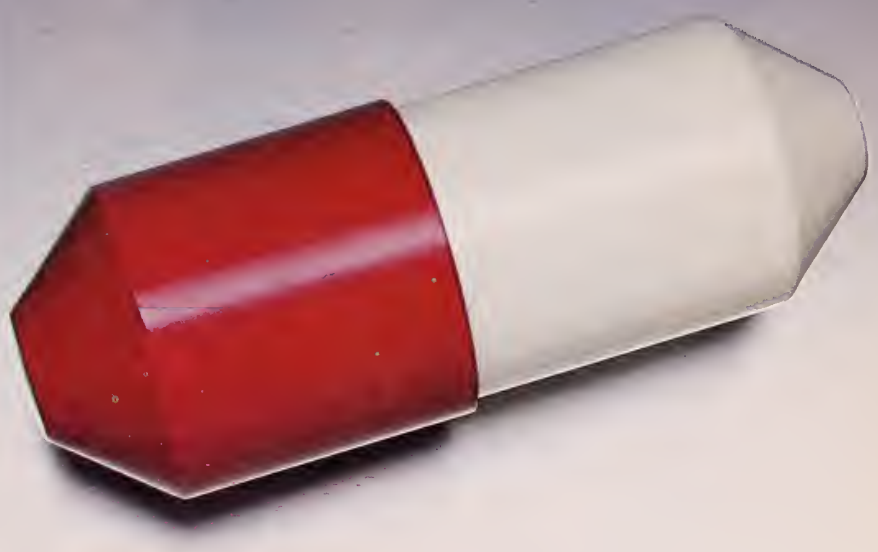
J.N. Brouillette, M.D.
Winter Park

Editor's Note: Efforts by the state legislature to protect physicians against the virus have so far been unsuccessful. Tallahassee keeps manufacturing the wrong vaccine.

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Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

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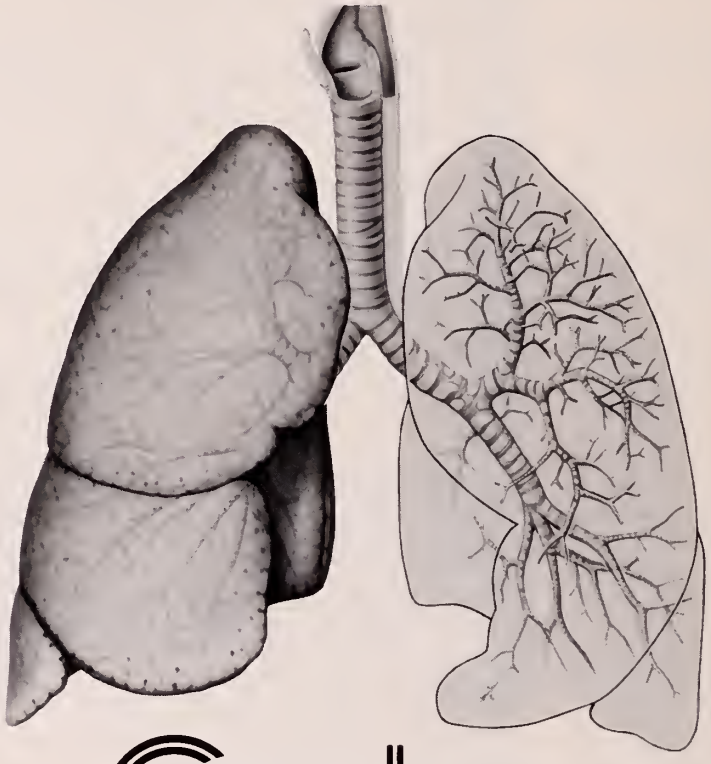
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Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae and *Streptococcus pneumoniae*
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly). [061787L]

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630



ZOVIRAX®
(acyclovir)
CAPSULES

Prevent genital herpes recurrences month after month with daily therapy.

(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)

Please see last page of this advertisement for brief summary of prescribing information.

ZOVIRAX®
(acyclovir)
CAPSULES

Help free your patients from recurrences.

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks—month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

Please see brief summary of prescribing information on next page.



Prevent recurrences month after month*

ZOVIRAX® (acyclovir) CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psycho-social difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤10 ml/min/1.73/m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

Burroughs Wellcome Co., Research Triangle Park, North Carolina 27709



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PROCEEDINGS OF THE FMA HOUSE OF DELEGATES

The format of the Proceedings was changed to comply with the resolution passed at the 1986 Annual Meeting that required the use of the same format as the AMA.

FLORIDA MEDICAL ASSOCIATION, INC.
113th ANNUAL MEETING
DIPLOMAT HOTEL, HOLLYWOOD, FLORIDA
SEPTEMBER 16-20, 1987

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 113th Annual Meeting at 10:30 a.m. on Thursday, September 17, in the Regency East/South of the Diplomat Hotel, Hollywood, Florida, with Guy T. Selander, M.D., Speaker of the House, presiding. The Saturday session, September 19, and the Sunday session, September 20, convened at 2:00 p.m. and 8:00 a.m. respectively, in the Regency East/South.

INVOCATION AND PLEDGE OF ALLEGIANCE: The House rose for the invocation which was given by Charles J. Kahn, M.D., remained standing for the Pledge of Allegiance and the singing of "The Star Spangled Banner," led by Arthur L. Eberly, M.D., and played by Pierre J. Bouis Jr., M.D.

INVOCATION

Oh Lord of all, look with favor on those assembled here; grant them the wisdom and unselfishness to reach decisions based on the greater good for all. May each of us draw strength from the dedication and commitment to service of our colleagues. May we be ever grateful for the glorious gifts of life and service in a most noble profession. Despite the burden of ills which seems to beset us, we must always remember that we have been blessed far beyond the expectations of most of mankind and that with this blessing comes responsibility over and above that placed on others. Help us to solve the problems engendered by an ever increasing body of knowledge and to cope with restrictions brought about by change over which we have no control. May He who guides the destiny of the universe show the way to peace and contentment to those here and to all mankind. Amen.

A. H. Robins Company Award "For Outstanding Community Service by a Physician"

Alvin E. Smith, M.D., a practicing physician of Internal Medicine, Hematology, and Oncology in Daytona Beach, Florida, has been selected by the Board of Governors of the Florida Medical Association, upon nomination of the Volusia County Medical Society, as the recipient of the 1987 A. H. Robins Company Award For Outstanding Community Service By A Physician.

A native of Daytona Beach, Florida, Dr. Smith received his medical degree from the University of Miami. He completed additional medical training at Fitzsimmons General Hospital (Rotating Internship) 1964-1965; Internal Medicine Residency, Tripler General Hospital, Honolulu, Hawaii, 1965-1968; Assistant Chief, Department of Medicine, Walson Army Hospital, Ft. Dix, New Jersey, 1968-1969.

Dr. Smith is a member of the Volusia County Medical Society in which he has served as President, 1984-1985, and Secretary, 1982-1983.

He is also a very active and valuable member of the Florida Medical Association serving on the Board of Governors, 1983-present; FLAMPAC District Representative, 1980-1983; and on the Continuing Medical Education Committee, 1984-present.

This fine physician has also held leadership roles in several hospitals where he practices including President, Medical Staff, Halifax Hospital Medical Center (1980-1981); Member, Board of Trustees, Daytona Community Hospital (1975-1977); President of Medical Staff, Daytona Community Hospital (1977-1979); Executive Committee, Ormond Beach Memorial Hospital (1976-1977).

He has also worked tirelessly in his specialty serving as Chairman, Nominating Committee, 1978, Florida Society of Clinical Oncology; as a member of the American Society of Clinical Oncology, University of South Florida, 1978-present; and as Medical Director, Respiratory Therapy Course, Daytona Beach Community College.

Dr. Smith has further served his community and his fellow man through voluntary efforts with several organizations including: The American Cancer Society (East Volusia Chapter); Board of Directors, 1975-present; First Vice-President, 1979-present; President, 1981; the American Cancer Society (Florida Division); Board of Directors - District II, 1980; Research Committee, 1978-present; Chairman, Research Committee, 1982-present; Executive Committee, 1982-present.

Florida Medical Association, Inc.,
1987 Distinguished Layman Award

Whereas, Mrs. Shirley D. Coletti of St. Petersburg, Florida, has been a tireless and stalwart worker in the area of substance abuse education and prevention; and

Whereas, she has served since 1970 to present as Executive Director of Operation PAR, Inc. (Parental Awareness and Responsibility); a comprehensive drug abuse education, prevention and treatment program in Pinellas County, Florida; and

Whereas, in 1986 Operation PAR was honored by being awarded "The Most Outstanding Program in the United States" by the Alcohol and Drug Problems Association of North America; and

Whereas, on June 12, 1986 President Ronald Reagan appointed Mrs. Coletti to the United States Senate Caucus on International Narcotics Control, serving with seven United States Senators; and

Whereas, this well-known crusader was appointed by Secretary of Health and Human Services, Otis R. Bowen, M.D., to serve on the National Advisory Council on Drug Abuse; and

Whereas, Mrs. Coletti has traveled all over the world speaking on substance abuse as a Special Representative on behalf of the United States Department of State; and

Whereas, Mrs. Coletti has over the past several years freely donated her time, talents and energy to literally dozens of local, state and national organizations to combat drug abuse through educational strategies; therefore be it

RESOLVED, That upon unanimous vote the Board of Governors of the Florida Medical Association at its 113th Annual Meeeting presents to Mrs. Shirley Coletti its Distinguished Layman Award.

Florida Medical Association, Inc.,
1987 Distinguished Layman Award

Whereas, Mr. Charles E. Mendez Jr., has been a tireless and generous supporter of drug education programs as President of the Charles E. Mendez Foundation founded by his father in 1963; and

Whereas, the Foundation has a special interest in helping children and has sought to do so by drug prevention education programs; and

Whereas, in 1977 the Foundation under the direction of Mr. Mendez began an education program that has gone into the Hillsborough County School System teaching children at a very early age the adverse effects of drugs and how to escape their grasp; and

Whereas, the Foundation's program now has been implemented across the country in more than 70 school districts from California to Connecticut and more than 2,000 teachers are now trained in the program; and

Whereas, the program has been the subject of conferences by the American Association of School Administrators and the Drug Enforcement Administration of the United States Government; and

Whereas, Mr. Charles Mendez guides the Foundation as its President and through the vehicle of private activity combats one of the great problems facing our time; therefore be it

RESOLVED, That upon unanimous vote the Board of Governors of the Florida Medical Association at its 113th Annual Meeting in Hollywood, Florida, September 16-20, 1987, presents to Mr. Charles E. Mendez Jr., its Distinguished Layman Award.

Florida Medical Association and Florida Physicians Insurance Company
1987 Malpractice Prevention Award:

J. Darrell Shea, M.D., a practicing surgeon in Orlando, Florida, has been selected by the Board of Governors of the Florida Medical Association, upon nomination of Orange County Medical Society, as the recipient of the 1987 Malpractice Prevention Award.

Dr. Shea has served as a member of the Florida Board of Medicine since 1981 and was chairman of the Board in 1985-1986. As a Board of Medicine member, Dr. Shea is responsible for the quality of medicine in the State of Florida. In addition to licensure and discipline, another function of the Board is education. Dr. Shea, through his monthly column, FBM Brief, in the Orange County Medical Society's publication, *Central Florida Physician*, attempts to educate OCMS physicians in how to practice medicine in such a way as to keep communication open between themselves and their patients and to avoid problems before they reach a point where a malpractice claim may be instituted. Dr. Shea's columns keep OCMS physicians current with changing statutes which will affect the practice of medicine.

A native of New York state, Dr. Shea received his medical degree from the University of Rochester School of Medicine in 1960. He completed a surgical internship at the University of Rochester in 1961 and completed a general surgery residency there in 1962.

After completing two years in the United States Air Force (1962-1964) as a general surgeon, Dr. Shea completed a three-year residency in orthopaedic surgery at the University of Pittsburgh. He then completed a "Research Fellowship" at Oxford University, Oxford, England.

Dr. Shea practiced medicine in Pittsburgh from 1967-1969 prior to moving to Jackson Memorial Hospital, Miami, Florida in 1969. He practiced there until 1972 when he moved to Orlando. He is currently Medical Director of Lucerne Spinal Injury Center, Humana Hospital Lucerne, Orlando, Florida. He is also an active staff member of Orlando Regional Medical Center and Holiday Hospital, also in Orlando.

He is a member of numerous state and national medical societies including Orange County Medical Society, Florida Medical Association, Southern Medical Association, American Medical Association, Florida Board of Medicine, Florida Spinal Cord Injury Advisory Council, Citrus Orthopaedic Society, Florida Orthopaedic Society, American Spinal Injury Association, American College of Surgeons, and the American Academy of Orthopaedic Surgeons.

Dr. Shea is always willing to share his knowledge with others for the advancement of medical science.

In addition to the monthly columns Dr. Shea writes for the Orange County *Central Florida Physicians* magazine, he has also authored several medical articles over the years on various aspects of orthopaedic surgery.

Harold S. Strasser, M.D.
Good Samaritan Award

Whereas, Samuel Hunter, M.D., of Pompano Beach, Florida who received his M.D. from Cornell University Medical School; and

Whereas, after residencies in the United States Public Health Service in Boston and New York returned to his birthplace to begin practice; and

Whereas, Dr. Hunter, a practitioner of Internal Medicine, volunteers his services to the Sunshine Health Centers in the migrant labor camps and has volunteered to serve as Broward County Medical Association's representative on the Board of Governors of that Institution; and

Whereas, this dedicated humanitarian is currently one of a group of nine black physicians; children of ministers and missionaries who wish to create Broward County's first full service, indigent oriented, private medical practice in an economically depressed Pompano Beach neighborhood; therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors, the Florida Medical Association at its 113th Annual Meeting presents to Samuel Hunter, M.D., the Harold S. Strasser, M.D., Good Samaritan Award with sincere appreciation for his humanitarian acts on behalf of his fellow man.

Florida Medical Association, Inc.
Certificate of Merit Award

Whereas, Luis M. Perez, M.D., of Sanford, Florida has rendered exceptional service to the Florida Medical Association, to organized medicine and to the public; and

Whereas, this dedicated physician attended the Havana Medical School where he received his medical degree and completed post-graduate work in internal medicine and cardiology at Georgia Baptist Hospital in Atlanta; and

Whereas, Dr. Perez served as personal physician at the Florida State Hospital in Chattahoochee, Florida, and in 1963 opened a private practice of internal medicine and cardiology in Sanford, Florida; and

Whereas, this patriotic physician has served organized medicine at all levels including Past President of the Seminole Medical Society; Past President of the Florida Medical Association, (1985-1986); delegate to the American Medical Association (1981-present) and as a Board Member of FLAMPAC, and

Whereas, Dr. Perez has served many other medical organizations, the Florida Society of Internal Medicine, American College of Chest Physicians, Southern Medical Association, World Medical Association, and International College of Angiology; and

Whereas, this gentleman physician has also served his fellow man in many civic endeavors, including Founder of the Seminole County Drug Action Committee, member and secretary of the Civil Service Board, and Founder and Advisor of THE GROVE, a drug detoxification center; and

Whereas, Dr. Perez has received many honors and awards including the A.H. Robins Award for Outstanding Community Service, Florida Medical Association Malpractice Prevention Award, Americanism Medal from the Daughters of the American Revolution, Dr. Benjamin Rush Bicentennial Award, American Medical Association Speakers Award and Sanford Kiwanis Club Outstanding Community Services Award; and

Whereas, Dr. Perez has given freely of his time and talents to the medical community and to the people of the State of Florida; therefore be it

RESOLVED, That a Certificate of Merit be presented to Luis M. Perez, M.D., as a token of the warm regard and respect that the Association holds for the many years of outstanding service rendered by this exceptional physician.

Florida Medical Association Inc.,
Certificate of Appreciation Award

Whereas, T. Byron Thames, M.D., of Orlando, Florida, tirelessly and ably has served the medical profession and the Florida Medical Association since 1958; and

Whereas, Dr. Thames was born in Elba, Alabama, November 13, 1930, attended Duke University where he received his medical degree in 1955; and

Whereas, this able physician interned at Duke Hospital for six months and rotating internship at Walter Reed Army Hospital, 1955-1956; and

Whereas, this honorable individual served as a flight surgeon in the United States Air Force, 1956-1958; and

Whereas, this outstanding medical leader has served in the Florida Medical Association in many capacities including President (1980-81); FMA Delegate to the American Medical Association (1981-present); Member, Board of Governors, 1973-1983; Member, Board of Directors, Florida Physicians' Insurance Reciprocal, 1978-1984; Vice President, Florida Medical Foundation, 1978-1983; and

Whereas, this dedicated physician has served other branches of organized medicine including the Orange County Medical Society (Past President 1970), The American Academy of Family Physicians (Past President 1976-1977), Florida Industrial Medical Association (Past President 1970); and

Whereas, Dr. Thames has worked tirelessly as Chief Medical Consultant to several Orlando companies including Walt Disney World, Coca Cola, Sea World, Orlando Utilities Commission, Sentinel Communications, Westinghouse, and Southland Corporation; and

Whereas, he has participated freely in many civic activities such as the Orlando Rotary Club, Goodwill Industries, Mental Health, 11th District, Meals on Wheels, Valencia Community College; and

Whereas, Dr. Thames has continually given of his time and talents for the enhancement of quality health care for all citizens; therefore be it

RESOLVED, That a Certificate of Appreciation be presented by the Florida Medical Association to T. Byron Thames, M.D., as a token of the warm appreciation that the Association holds for this fine gentleman and his exemplary record of service to mankind and to his profession.

1987 Medical Speakers Awards

Florida's medical profession has benefited in recent years from increased communications on the part of the county medical societies and their physicians through health-related television and radio programs.

The FMA encourages this type of media activity. In fact, we established the Medical Speakers Awards to recognize some of these outstanding programs and the people behind them.

This year we have seven first place winners. Each winner will receive a plaque and check for $100. In addition, two honorable mentions will be presented a certificate noting their achievements.

In the category of **Organizational Television,** our first place award goes to the Duval County Medical Society for its weekly program, "**To Your Health.**" This 38-program series airs three times each week on Continental Cable 34 in Jacksonville. The show represents a long-term commitment on the part of the Duval County Medical Society to give its community much needed medical and health information that helps citizens better utilize the total health care delivery system. Dr. Wilbert L. Dawkins Sr., President of the Duval County Medical Society, accepted this award.

We also have an honorable mention to award for **Organizational Television.** It goes to the Orange County Medical Society for its program, "**Health Horizons.**" This weekly, 30-minute program provides medical education on timely topics of interest to the Central Florida community. Dr. Wayne L. Godbold, President of the Orange County Medical Society, accepted this award.

In the category of **Organizational Radio,** First place goes to the Duval County Medical Society for its program, "**Ask The Doctor.**" This weekly one-hour, call-in program is broadcast over WOKV-AM Radio in Jacksonville. Guest physicians talk about topics ranging from the malpractice crisis and what it actually costs patients, to child psychology and plastic surgery. This is the fifth year in a row that Duval County has won first place in this category. We congratulate them for a dedicated, continuing effort to provide up-to-date medical health information to the public. Dr. Wilbert L. Dawkins, Sr., President of the Duval County Medical Society, accepted this award.

In our **Individual Television** category, Dr. Michael C. Hughes wins first place for a weekly 30-minute show called "**Newsmakers.**" The show presents a spectrum of issues that relate to public policy, law, medicine and other issues. Dr. Hughes accepted the award.

Our next category is **Individual Radio** and this year's winner is Dr. Kevin M. McAuliffe, a Jacksonville ophthalmologist. Dr. McAuliffe answered questions regarding ophthalmology and represented Duval Coun-

ty on "**Ask The Doctor,**" which airs on WOKV-AM Radio in Jacksonville. Dr. Wilber L. Dawkins Sr., President of Duval County Medical Society, accepted this award on behalf of Dr. McAuliffe.

We have an honorable mention in **Individual Radio** this year and it goes to Mr. Ron L. Fitzwater, Executive Vice President of the Orange County Medical Society, for "**WUCF Health Update.**" This weekly, one-hour program is a medical information call-in show that discusses medical items of interest to citizens of Central Florida. Mr. Fitzwater accepted this award.

A team effort produced this year's winning entry in **Individual Live Audience For Television.** The team, Dr. Kimberly Jaffee of Vero Beach and Mrs. Betsy Root, a registered dietician at Indian River Memorial Hospital in Vero Beach, presented a six-week course called "**Healthy Heart Cuisine.**" It was designed to help people learn how to make their diets healthier. Dr. Jaffee and Mrs. Root are from Indian River County Medical Society. Dr. Jaffee and Mrs. Root accepted their awards.

Our last Medical Speakers Award goes to the Duval County Medical Society for its **Public Relations Campaign, "The Mini-Internship Program."** The program, which began in August 1985, runs monthly with eight physicians and four private citizen interns. Interns make rounds with physicians on two consecutive days followed by two evening meetings. Dr. Wilbert L. Dawkins, Sr., President of the Duval County Medical Society, accepted this award.

Again, we wish to thank those whose hard work made these programs possible.

1987 Scientific Exhibit Awards

Pierre J. Bouis Jr., M.D., Chairman, Council on Scientific Activities, announced the winners of the 1987 Scientific Exhibit Awards.

First Place — Operative Cholangiography in 885 Consecutive Cholecystectomies — *Dr. Banning G. Lary.*

Second Place — Influence of Nutrition on Immunity and Longevity, Diseases of Angina and Malignancies — *Drs. Robert A. Good, Dau M.L. Johnson, B.C. Ogura, H. Ogura, R.P. Thau, John Risley.*

Third Place — Florida's First Cardiac Transplantation Program — *Dr. R. Vijayanagar*

Honorable Mentions:

Intravenous Metoprolol in Suspected Acute Myocardial Infarction: Clinical Experience — *Drs. Peter Schulman, William J. Tenet, Alan S. Rosefeld.*

Antihypertensive Treatment with Metrolol or Hydrochlorothiazide in Patients Aged 60 to 75 years — *Dr. John Wikstrand.*

Estrogen Replacement Therapy: A Comparison of Transdermal Estradiol and Oral Conjugated Estrogens — *Drs. William D. Lawrence, Donald S. Horner, M.D.*

Legislators Certificates of Recognition

Kay K. Hanley, M.D., Vice President, presented certificates to the following legislators in recognition for outstanding legislative services:

Senator Mattox Hair — In grateful appreciation of 14 years of outstanding and dedicated legislative service in promoting quality health care for the citizens of the state of Florida with special recognition on untiring personal efforts to resolve the professional liability crisis in Florida.

Senator Tim Deratany — In grateful appreciation of outstanding and dedicated legislative service in promoting quality health care for the citizens of the state of Florida with special recognition on untiring personal efforts to improve trauma and emergency medical care in Florida.

Senator William "Doc" Myers — In grateful appreciation of outstanding and dedicated legislative service in promoting quality health care for the citizens of the state of Florida.

Representative David L. Thomas, M.D. — In grateful appreciation of outstanding and dedicated legislative service in promoting quality health care for the citizens of the state of Florida with special recognition of the unselfish personal sacrifices of the time and energy in representing the profession of medicine and the patients of Florida.

Representative Susan Guber — In grateful appreciation of outstanding and dedicated legislative service in promoting quality health care for the citizens of the state of Florida.

Representative Betty Metcalf — In grateful appreciation of outstanding and dedicated legislative service in promoting quality health care for the citizens of the state of Florida.

Representative Alzo J. Reddick — In grateful appreciation of outstanding and dedicated legislative service in promoting quality health care for the citizens of the state of Florida with special recognition of untiring efforts to provide a comprehensive indigent health care program for those in need.

Represenative Bolley L. Johnson — In grateful appreciation of outstanding and dedicated legislative service in promoting quality health care for the citizens of the state of Florida with special recognition of untiring personal efforts to improve trauma and emergency medical care in Florida.

1987 Awards for Excellence in Medical Journalism

Dr. Hanley announced that the 1987 awards for Excellence in Medical Journalism were presented at the Editor's Luncheon on Wednesday, September 16.

Print Entries

Dailies Over 50,000 — **1st Place: "AIDS: Close to Home"**, *The Miami Herald,* Ena Naunton, Cathy Lynn Grossman, Margaria Fichtner, Jane Wooldridge, Polk Laffoon; **2nd Place: "Breast Cancer"**, *Florida Today,* Jim Ash.

Dailies Under 50,000 — **1st Place: "Medicare"**, *The Leesburg Commercial,* Laura Williams; **2nd Place: "He Was So Sure He Was Going to Beat It"**, *The Bradenton Herald,* Alison Davis.

Weeklies/Semi-Weeklies — **"Johnny Steffen Story"**, *The Gadsden County Times,* Sarah Carey; **2nd Place: "DeBakey Heart Institute: JFK Medical Center"**, *The Lake Worth Herald,* Jo Ann Currier.

Magazines — **1st Place: "Special Report on Aging"**, *SPIRITUS Magazine,* Celeste O. Cox and Pat Keeler; **2nd Place: "Healthcare: Orlando's Industry of Tomorrow?"**, *Orlando Progress Report 1987, Office Guide to Orlando,* Ruth W. Paton.

Audio-Visual Entries

Television (Major Market) — **1st Place: "Target 8: IMC Gold Plus"**; *WXFL TV-8, Tampa,* Mark Lagerkvist; **2nd Place: "Beyond the Burn — Skin Cancer"**, *WFTV TV-9, Orlando,* Todd A. Ulrich.

Television (Other Markets) — **1st Place: "Hope or Hoax: Oral Chelation"**, *WBBH TV-20, Ft. Myers,* Bob Austin; **2nd Place: "Healthwatch on Crack Cocaine"**, *WTXL, Tallahassee, Joe Larkins.*

Honorable Mention: **"Catheterism Test"**, *WSCV TV-51, Hollywood,* Marilys Llanos; **"HMOs: Too Good to be True"**, *Florida Public TV, Tallahassee,* Keith A. Miles.

Radio — **1st Place: "Coping With Cancer"**, *WJNO, West Palm Beach,* Chuck Elderd; **2nd Place: "Under Pressure: A 5-Part Series on Hypertension"**, *WDBO Newsradio 58, Orlando,* Mike Yardley.

Petition Drives Awards

Mrs. Susan Marks, President of the FMA Auxiliary, presented awards to counties and individuals who excelled in the petition drive. The Auxiliary undertook the task of collecting signatures for a constitutional amendment to be placed on the ballot that would put a cap on noneconomic damages of $100,000.

Mrs. Marks also thanked Mr. Donald W. Weidner, Esq., Mrs. Mary Kay Samorisky and Mr. Robert W. Seligson of the FMA Staff for their assistance with this campaign.

A plaque was presented to the Broward County Medical Association Auxiliary for collecting the greatest number of petitions. Dr. Peter A. Tomasello, President of the Broward County Medical Association, accepted this award on behalf of the Broward Auxiliary.

A plaque was presented to the Pasco County Medical Society Auxiliary for the highest percentage of their membership to sign the petition.

A plaque was presented to Mrs. Ester Foley of the Duval County Medical Society Auxiliary as the individual who obtained the greatest number of signed petitions.

Certificate of Commendation
Mr. William H. Dodd

A certificate of commendation was presented to Mr. Williams H. Dodd for his untiring contributions to the Committee on Relative Value Studies and in the preparation of the *Florida Relative Value Studies* book.

REPORT OF THE CREDENTIALS COMMITTEE

The membership of the Credentials Committee consisted of Richard J. Bagby, M.D., Chairman; Thomas D. Bartley, M.D.; Peter A. Tomasello, M.D.; Jeffrey B. Raskin, M.D.; Dale L. Taylor, M.D.

On Thursday, September 17, Dr. Bagby reported that 205 delegates representing 36 county medical societies and 14 specialty groups were seated, thus constituting a quorum; on Saturday, Sept. 19, 263 delegates, representing 29 county medical societies and 14 specialty groups, were seated; and on Sunday, September 20, 225 delegates, representing 36 county medical societies and 9 specialty groups, were seated.

RULES AND ORDER OF BUSINESS
Thursday, September 17

HOUSE ACTION: ADOPTED

The Rules and Order of Business for the House of Delegates are included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. The Bylaws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Your attention is called to the format of the Annual Meeting, where the Reference Committee meetings will be held on Friday morning, following the First Meeting of the House on Thursday morning. All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the House of Delegates. Members may request the Reference Committee chairmen to defer items in which they are interested in order that they may be present to discuss the subject.

All resolutions **must have a sponsor present before the Reference Committee**. Resolutions must be filed by 12:00 noon on the day before the First Meeting of the House of Delegates, typewritten and

in proper form. The resolutions so presented will be available for distribution by the time the First House convenes. Only the "Resolved" portion of the resolutions will be adopted as policy.

All Reference Committee reports will be duplicated and available to the delegates at the Registration Desk on Saturday. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook (as well as the reports of the Reference Committees) have been printed on colored paper for easy reference. This color code is as follows:

Reference Committee No. I — Green
Reference Committee No. II — Tan
Reference Committee No. III — Blue
Reference Committee No. IV — Pink
Reference Committee No. V — Goldenrod

According to our Bylaws, nomination and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

EMERGENCY RESOLUTION — MEMBERSHIP

Rally in Tallahassee
Submitted by Dade and Hillsborough County Medical Associations

HOUSE ACTION: ADOPTED

The Emergency Resolution asks that the FMA make plans for a membership rally in Tallahassee at the time of the special session of the Florida Legislature.

APPROVAL OF MINUTES

The Proceedings of the 112th Annual Meeting of the House of Delegates were approved.

REMARKS OF THE SPEAKER

The following remarks were presented by Guy T. Selander, M.D., on Thursday, September 17:

HOUSE ACTION: REFERRED TO REFERENCE COMMITTEE NO. III

Welcome to the 113th Annual Meeting of the Florida Medical Association. As Delegates to this House, whether representative of your county society, specialty group, hospital staff section resident or student sections, it is your responsibility to see that the business of the FMA House of Delegates is conducted in a manner that will best serve the interests of the people in Florida and the entire medical profession, as well as the FMA membership.

According to the Bylaws, "The House of Delegates is the legislative and business body of the Association". A quorum consists of a majority of the delegates and a majority of the component medical societies. Each component society selects one delegate for every forty active members. Additionally, each specialty society recognized by the FMA, the Council on Hospital Staffs, The Medical Student Section and the Resident Section select one delegate entitled to vote at this meeting.

The privilege of the floor shall be restricted to seated delegates, officers, presidents of the county medical societies, members of the Board of Governors, AMA delegates, past presidents, members of the Council on Specialty Medicine, Council Chairmen, a representative of the FMA Medical Student

Society, and AMA General Officers and Past Presidents, who are FMA members, except by permission of the presiding officer. This privilege includes the right to make motions, provided they are seconded by a voting member of the House.

The format for this year's meeting will be as follows:

Today, the First House will meet as outlined on page 21 of your Delegates Handbook. Reports and resolutions will be assigned to the appropriate reference committees.

Tomorrow, Friday, as in the past, five reference committees will meet to discuss the business of the Association. This is where discussion and debate should take place, so that a consensus can be reached by each Reference Committee for presentation to the second and third houses. Reference Committees, I, II, IV & V will meet in their assigned rooms promptly at 8:30 a.m. Reference Committee III will begin at 9:30 to begin discussion of its regular agenda, and at 10:30 will take up consideration of a special report on professional liability. This is being done so that everyone may have an opportunity to participate in this vital issue without disrupting the necessary work of the other reference committees.

Any member who feels compelled to speak at more than one Reference Committee may ask the Reference Committee Chairman to hold discussion on a particular agenda item until a certain time. At the conclusion of the Reference Committee deliberations, each committee will retire to executive session to prepare the Reference Committee Report. It is our intention to have one copy of each report for each component medical society by Friday afternoon.

The Second House will convene on Saturday at 2:00 p.m. It is Dr. Eberly's and my intent to discuss at least three reference committee reports during the second house. During the session we will accept nominations for the elective offices outlined on page 22 in your handbook. We will, as we did last year, recess promptly at 4:30 p.m. so that everyone has time to prepare for the President's Inauguration at 5:30 in the Regency West Room.

The Third House will convene on Sunday morning at 9:00 a.m. Elections will be held by ballot beginning at 7:00 a.m. outside this room, using voting booths as in the past. The election results will be announced during the Third House, and runoffs, where necessary, will be conducted by written ballot here on the floor of the House. The remaining reference committee reports will be presented, and the remainder of our business concluded.

Every delegate is required by the Bylaws to fill out an attendance card at **each** meeting of the House. The Chairman of the credentials committee will report to the House the number of delegates registered, eliminating the need for a roll call. As in the past, our deliberations are governed by Parlimentary Procedure as contained in *Sturgis' Standard Code of Parliamentary Procedure,* unless otherwise provided by the FMA Bylaws or modified by a 2/3rd vote of the members present at any session.

You, the delegates, are the elected representatives of the members in your counties, specialty section, hospital section and resident and student sections. It is your responsibility to deliberate and make decisions for those you represent. It is the intent of your Speaker and Vice Speaker to allow all to be heard. Again, remember that if appropriate discussion takes place at the Reference Committees, the work of *this* House can be carried out more expeditiously. When speaking on the floor of the House, please try to be concise and make *pertinent* remarks.

Once again, we have our work cut out for us for the next four days. If we all work at it, much can be accomplished.

INTRODUCTION OF THE PRESIDENT

Speaker Guy T. Selander, M.D., introduced FMA President James B. Perry, M.D.

Now, ladies and gentlemen, we are about to come to one of the highlights of our Annual Meeting program . . . the report of our president.

The twelve months that have passed since we last met have been tumultuous ones, with most of our problems being related in one way or another to the continuing professional liability crisis. We have seen the Supreme Court of this state wipe out the gains made in the 1986 Legislative Session. And

because of the added exposure to possible lawsuits, many specialists in parts of the state have discontinued providing emergency room back-up or handling trauma cases.

And while we still look for a solution to the crisis, we have survived the year alive and well under the able leadership of our president, Dr. James B. Perry.

As the issues facing us multiply and become more intense, the job of President of the Florida Medical Association required increasing commitment and time. For the past twelve months, Dr. Perry has been almost a full-time president. Because of his policy of being available to newsmen at virtually any time, Jim Perry in the minds of many *is* the FMA.

It is estimated that since last September our president has represented us at about 120 meetings related to the professional liability crisis. He has presented testimony and participated actively in such groups as the Academic Task Force and the Governor's Task Force on Emergency Room and Trauma Care.

Building on foundations laid by his predecessors, Dr. Perry has moved us closer, I believe, to a solution to the PLI crisis.

He has carried our cause to the Legislature, the Governor, the Academic Task Force and the people, through the media. He has relayed our message in interviews and talk shows on national television and in interviews with USA Today, American Medical News and virtually every metropolitan newspaper in this state.

He has worked to secure the active cooperation of state hospital organizations and other groups. And he has kept open lines of communication with the Florida Bar and the trial lawyers.

Dr. Perry has presided over the gearing up for the anticipated session of the Legislature to deal with the liability crisis and for a constitutional amendment campaign for next year.

On the other hand, Dr. Perry's stewardship has been studded with important successes in other areas. Important among these is the indigent care legislation, to which our president was totally committed.

During his tenure, our president has shown total selflessness in his devotion to his responsibilities. The fact that we do not yet have a solution to the liability crisis should not detract from that.

Ladies and gentlemen, your president, Dr. James B. Perry . . .

ADDRESS OF THE PRESIDENT

The following remarks were presented by James B. Perry, M.D., on Thursday, September 17:

HOUSE ACTION: REFERRED TO REFERENCE COMMITTEE III

My friends and colleagues, perhaps it's appropriate that this meeting is today. Two hundred years ago on September 17, in 1787 at about this time, the Constitution became the testament of our great nation. This has been quite a year. The rollercoaster ups and downs have been mindboggling, and as one could expect, at times your heart is in your throat and your stomach in your more posterior portions. At times, your president and board felt that, perhaps, a degree of stability could be reached in the area of professional liability insurance availability and affordability with a legislature that had "addressed the problem in 1986." This feeling of relative complacency lasted only a few moments and was never to be a significant factor.

Last year, our Immediate Past-President Luis Perez stressed unity and a commitment. The 1986 law was to be a solution to the professional liability problem. With the wishful hope that 1986 would begin to solve the PLI problem and the strength of the laws then on the books would be interpreted in a way to continue to address the issue, it was felt that the current year was to stress four areas of concern.

The first was the Auxiliary and our desire to be more closely allied with these very supportive individuals. It was felt that they should become amalgamated into our legislative program and in activating a medical

action team. Our desire was to have closer liasion with them at that level and at board level. Susan Marks and her excellent staff and helpers (Mary Kay Samorisky, Lee Pass and Attorney Don Weidner) were to be a keystone in this area.

The second thing we launched was an initiative to begin a more realistic involvement, with the dynamic approach, to the delivery of medical care to the needy citizens of our state. We knew that this population was approximately 25 percent of our total and crossed all ethnic, religious and racial lines in approximately equal percentage reflective of their population demographics. There was a special issue of the *Journal*, and a symposium during the leadership conference dedicated to this problem. Both were outstanding, and have been, and will be emulated in the future throughout the country. With our staff and with perseverance, we were able to effectively draft and influence legislation that passed and, for the first time in decades, began to tackle the problem of indigent care here in the state of Florida.

Thirdly, we had hoped to address the problem of ethics in medicine. Not just the daily problems in ethics, with which we are all familiar, but more complex relationships between ourselves, our families, our spouses, our children and our creator. The fact that we were so fortuitously opportunistic is amply demonstrated in this month's special issue of the *Journal* and the symposium to be held here on Friday devoted to this, perhaps, most important subject.

The last, and perhaps what turned out to be the most time consuming and recalcitrant problem, was that of professional liability. As you know, all of the carriers, because of the increase in severity and frequency of suits, were obliged to limit or reduce coverage, cancel some physicians and threaten to or actually remove their companies from the Florida market. This created an impossible dilemma for every physician in the state. The problem and solutions to it had to be addressed with numerous meetings in Tallahassee, Jacksonville and literally every area of the state. It was obvious that nothing would be attempted in the legislative session because of their commitment to the report of the Academic Task Force, funded by their tax dollars and because they also were tired of the problem. Yet on January 1 and again on July 1 (anniversary dates of policy renewals) crisis continued to escalate and be carried over to every segment of the physician population. The dilemma is not limited to just professional liability, but all liability is, in fact, involved. The absolute necessity of addressing the issue of the health care access crisis had to be tackled. It took a great deal of persuasion from your Association, as well as efforts from numerous physicians and county societies, with the tremendous support from every member of the now unified group, to bring this about. Not to single out any one county or area, but the southeastern section had a very positive impact because of their special situations. The pregnant mothers from Palm Beach and other county and local groups from Jacksonville, from Lee to Collier and Sarasota and from Escambia to Key West, all became activists and were extremely helpful in bringing the problem to the public's conscience. We had a very positive and strong effect from Vice President Bush personally, and also from the Secretary of the Department of Professional Regulation here in Florida, Mr. Van Poole, and now his successor Tom Gallager.

Efforts to help resolve the problem even now are continuing. We have had at least 5-6 meetings personally with the Governor and have corresponded with his office on a dozen other occasions. His Chief of Staff, his Lt. Governor and Special Task Force Director Bill Bryan have all been contacted numerous times.

I cannot promise *you*, this Association or the people of Florida that there will be a solution to our problem that will resolve the difficulty partially or permanently. Knowing the history of our state and the implications of conflict and adversarial forces, I can only say that we are making strides now and we shall not rest until a permanent resolution of the difficulty is finally implemented. The Gunter Proposal — from numerous, occasionally lengthy president's memos you realize the necessity of total animosity and recalcitrance to any mandatory, state-run socialistic taxist insurance scheme. If that were to be shoved down the throats of the people of Florida, I would ask that every physician living in the state consider his own recognizance locating in another area.

As we move forward, we must realize that we are the servants of our own ethic; our profession; and directly flowing from that, our patients. The individual, the patient, the family are the backbone of this great America, and we must realize that they always come first and foremost. We hope that our legislative colleagues will give us the tools to effectively discipline wayward members of our profession who do, on occasion, gouge or cheat. There are also those who persistently and knowingly practice in a manner that causes us to cringe, or seems to bring discredit to the profession, collectively or individually. This can never be tolerated and must be controlled. But only as a small tangent of the permanent solution. Liability must be removed from the tort system.

Rather than go into all sorts of details, I would encourage each and every one here to review the History of the Professional Liability Crisis as outlined in Report C of the Handbook and the History of Malpractice Legislation in Florida 1875-1987.

Now, I want to take a few minutes to offer thanks to, first of all, my family. Especially my wife Peg who has put up with a preoccupied, somewhat distant husband for the last 28, and especially the last 12 months. Without her at my side, I certainly would have perished prior to the fulfillment of this year's obligations.

I want to thank especially the members of the Board of the Florida Medical Association. These people have been with us all the way and have been the support, the encouragement and the counsel without which no president or executive committee can succeed. I need to thank more than words or tokens can express the unending efforts of our staff from the newest member to the senior people. To mention just a few without overlooking anyone would be impossible, but I do think that Gerry Soud, Jim Richardson, Robert Fore, Russ Jackson, Ed Hagan and Bob Seligson are fantastic, knowledgeable and dynamic in their areas of expertise. This Association would be hard put without them. The secretaries, Linda Flowers and Lynn Mobarak and all of the others on the staff level, as well as the supportive level deserve our utmost thanks and considerations. Louise Rader came back and helped with the *Journal* and Sissy Crabtree has done a super job. The Public Relations Department, who have helped handle, field and direct tens of thousands of media calls and literally orchestrated when we needed to make comments to whom and how much — they all deserve our debt of gratitude.

As a special comment, I wanted to thank the Tallahassee staff, Scotty Fraser, George Palmer and Lucy Mohs, as well as the secretaries and field representatives, Bill Landis, Tad Fisher, Larry Gentry and Larry Lanier.

I cannot let this occasion slip by without commending John Thrasher, our legal counsel, who has done more than his duty and job requirements to pull so much together to orchestrate so much that has happened and to keep us on a legal straight and narrow that allowed this association to function day in and day out. Enough cannot be said to thank him for his efforts. Mr. Don Jones, our Chief Executive Officer and Executive Vice President, celebrated, just now, his 20th year with the Association. He has put in, on some occasions, 20 hour days and even then was thinking about what had to be done in the next day and the next week. He continued to pull it all together and direct it; as perhaps no other person in a similar position in any state of the country has had to do. No one has been able to do it with such success as has been demonstrated, especially, this year and as well as earlier years for this Association.

What do I see for the future — that is up to *you*. There are obvious areas of concern. We must find a way to be stronger advocates for our patients under the DRG and PRO edits. There must be fairness and justice tempered with love and concern. Both must work — not in a bureaucratic drum head way but in a compassionate equitable way. The PRO may be our solution to preventing full socialization with mandated fees and assignment as condition of licensure — such as is happening in Massachusetts and like those who are the liberal socialists would foster on an already overburdened taxpaying public.

Our success, our failure, depend on the effectiveness of every member of the Florida Medical Association team. The antithesis of divide and conquer is with unity there is strength. Our efforts are a culmination of the response to the unity and strength that very few people or organizations can ever begin to come close to. You have to be proud to belong. I must say that though I am a little tired after this year, I am honored to have been your leader for this short time. God bless you, keep you safe and, above all, allow you the opportunity to compete and to serve and to win.

Freedom, as our forefathers were aware, must be protected and must be worked for. It can never be taken for granted. Our failures and our experiences continue to strengthen us to accomplish this ultimate goal. Retirement is six feet deep — ladies and gentlemen, there is no finish line.

Thank you very much.

SPECIAL INTRODUCTIONS

Thursday, September 17

OFFICERS OF THE ASSOCIATION

James B. Perry, M.D., President
James G. White, M.D., President-Elect
Kay K. Hanley, M.D., Vice President
Henry M. Yonge, M.D., Secretary
Yank D. Coble Jr., M.D., Treasurer
Guy T. Selander, M.D., Speaker
Arthur L. Eberly, M.D., Vice Speaker
Luis M. Perez, M.D., Immediate Past President (absent due to illness)
Donald C. Jones, Executive Vice President

Rufus K. Broadaway, M.D., AMA Trustee
Edward R. Annis, M.D., AMA Past President
Mrs. Betty Seuchek, Belleville, Illinois, AMA Auxiliary President
Mrs. Susan Marks, FMA Auxiliary President
Mrs. Betty Orr, FMA Auxiliary President-Elect
Mrs. Priscilla Gerber, FMA Auxiliary, Southern Regional Director
Mrs. Virginia Hopper, President, Southern Medical Association Auxiliary

Saturday, September 19

Mrs. Betty Orr, FMA Auxiliary President
Mrs. Jane Eberly, FMA Auxiliary President-Elect
Mrs. Sue Bertiolette, AMA-ERF Chairman

Sunday, September 20

Jerald R. Schenken, M.D., Nebraska, AMA
Officer and a candidate for the open seat in the Second Congressional District of Nebraska

Marion Delegation: Henry L. Harrell Jr., M.D.; Douglas R. Murphy, M.D.; William A. Trice, M.D. and Richard B. Van Eldik, M.D., all sons of former FMA Delegates

AMA EDUCATION AND RESEARCH FOUNDATION (AMA-ERF)

Mrs. Susan Marks, Immediate Past President of the FMA Auxiliary, presented Dr. White with a check for $3,107.00 for the Florida Medical Foundation on Saturday, September 19. Mrs. Marks also recognized Florida's three medical schools who received checks earlier in the year from AMA Education and Research Foundation totalling $111,493.34.

IN MEMORIAM

Dr. Guy T. Selander, Speaker of the House, requested that everyone stand for a moment of silent prayer and meditation in memory of those members the Association had lost through death.

Adams, Daniel M. Bay
Anderson, Horace M. Duval
Baden, David D. Dade
Bevis, Victor S. Dade
Bilotta, Laurence A. Orange
Birely, Beverly R. Broward
Blaine, George Dade
Burbacher, Charles R. Dade

Caldwell Jr., John M. Dade
Calhoun, Laurie L. Marion
Callis, Charles M. Orange
Cameron, William R. Pinellas
Campbell, J. Robert Hillsborough
Cava, Edward E. Dade
Cohen, Alan B. Dade
Copenhaver, Richard M. Polk
Coplan, Milton M. Dade
Corwin III, James H. Duval
Crawley, Joseph H. Dade
Crespo, Artagnan Pinellas
Daughtrey, John E. Polk
Delos-Santos, Joseph Volusia
Dever, Richard C. Duval
Enzor, Allen A. Okaloosa
Enzor Sr., Rhett E. Okaloosa
Ferayorni, Richard R. Broward
Feuerman, Barry Dade
Florence, Hyman Dade
Fowler, William O. Orange
Fox, Edward F. Dade
Frazier, Truett H. Orange
Frederick, Albert R. Pinellas
Freeman, Jules Broward
Garcia, Francisco N. Broward
Getz, Alvin M. Dade
Glattauer, Alfred Dade
Gordon, Lionel Broward
Grable, James S. Hillsborough
Grochowski, Ernest M. Sarasota
Harris, William G. Duval
Hernandez, Heriberto F. Dade
Hernandez, Pedro O. Dade
Hewson, George F. Collier
Hickman, Jack W. Hillsborough
Hinton, Forrest Collier
Hirschfield, Alan M. Hillsborough
Hodge, Edgar B. Polk
Holecek, Frank Pinellas
Horstmann, Jorge A. Dade
Hulme, Kevin P. Brevard
Hundley, Joseph L. Orange
Ivany, Robert J. Dade
Jewett, Eugene L. Orange
Jimenez, Juan A. Dade
Johnson, Samuel H. Dade
Jones, Jenner G. Orange
Jordan, Otis L. Lee
Kazan, Avraam T. Sarasota
Keller, Theodore C. Dade
Kemper, Bennett I. Broward
King Jr., Albert G. Polk
King, Jerald P. Escambia
King, Raymond H. Duval
Kirk, Phillip B. Brevard
Landrum, Louis G. Columbia
Larios, Oscar H. Dade
Leon, Andrew J. Dade
Lippoldt, Charles L. Orange
LoCicero, Bernard J. Palm Beach
Lusskin, Harold Dade
Manrodt, Spencer C. Brevard
Maramara, Octavio O. Lee
McCoy, Donald L. Alachua
McKaig, Malcolm C. Pinellas
Miller, Neill D. St. Lucie-Okeechobee
Moore, Maurice R. Hernando
Morgan, Charles R. Citrus
Murphy, Eugene L. Escambia
Nix, Harold G. Hillsborough
Oren, Benjamin O. Dade
Owen, Clarence I. Duval
Paley, David H. Dade
Parkhurst, Leonard W. Capital
Paryani, Bhojraj Duval
Peacock, William F. Polk
Pejovic, Ilija Palm Beach
Pino, Mario J. Dade
Reddick, Hilliard R. Panhandle
Rigg, John F. Dade
Robinson, John R. Palm Beach
Santayana, Rafael A. Pinellas
Santos, Sixto R. Osceola
Schadel Jr., Lees M. Broward
Schildhaus, Leo J. Broward
Schosheim, Arnold M. Palm Beach
Serrano, Julio R. Broward
Shepperd, Lewis A. Dade
Simon, S. William Dade
Staryk, Steven E. Broward
Stuart, Jack F. Dade
Tamayo, Raul C. Broward
Tench, William R. Pinellas
Thompson, Clyde T. Dade
Thompson, Robert V. Dade
Trejo, Angel Monroe
Turek, Samuel L. Dade
Vacha, Victoria B. Orange
Vollenweider, Juan C. Okaloosa
Wachtel, Leo M. (FMA Past President) . Duval
Whorton, C. Merrill Duval
Wyman, Edward H. Sarasota
Zimmerman, Paul A. Dade
Zucker, Isadore R. Broward

REFERENCE COMMITTEE OF THE HOUSE OF DELEGATES

REFERENCE COMMITTEE I — HEALTH AND EDUCATION

Alvin E. Smith, M.D., Chairman, Volusia
Larry P. Garrett, M.D., Lee
Randall D. Bertolette, M.D., Indian River
Richard L. Glatzer, M.D., Dade
Herbert E. Brooks, M.D., Panhandle
Kay K. Hanley, M.D., Pinellas, AMA Delegate Advisor

REFERENCE COMMITTEE II — PUBLIC POLICY

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C. Davis Whelchel III, M.D., Duval
David A. D'Allesandro, M.D., Broward
Harold G. Norman, M.D., Dade
Gilbert R. Panzer, M.D., Palm Beach
Daniel L. Seckinger Jr., M.D., Dade, AMA Delegate Advisor

REFERENCE COMMITTEE III — FINANCE AND ADMINISTRATION

Bruce W. Weissman, M.D., Chairman, Dade
Paul T. Baroco, M.D., Escambia
Harold L. Ishler Jr., M.D., Pinellas
John B. Adamson, M.D., Brevard
Miguel R. Alonso, M.D., Hillsborough
Frank C. Coleman, M.D., Hillsborough, AMA Delegate Advisor

REFERENCE COMMITTEE IV — LEGISLATION

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Gaston J. Acosta-Rua, M.D., Duval
David L. Thomas, M.D., Sarasota
James A. Jordan, M.D., Broward
Julian H. Groff, M.D., Dade
T. Byron Thames, M.D., Orange, AMA Delegate Advisor

REFERENCE COMMITTEE V — MEDICAL ECONOMICS

Wilbert L. Dawkins, M.D., Chairman, Duval
John E. Perchalski, M.D., Hillsborough
Cecil B. Wilson, M.D., Orange
Sheldon Zane, M.D., Dade
Darrel W. Wyatt, M.D., Clay
Charles J. Kahn, M.D., Escambia, AMA Delegate Advisor

INAUGURAL ADDRESS

James G. White, M.D. was inaugurated as the 111th President of the Florida Medical Association on Saturday, September 19, 1987. Following is his Inaugural Address:

Thank you, Jim, both for that kind introduction and for a truly outstanding year of leadership of the FMA. When you began your year, we all knew you were a fine physician. During the year, we have learned you are a more than passable politician as well, having greatly contributed to both the strong image and the respect accorded this Association by officials of government; by the media and, lest we forget, other statewide organizations, such as the Bar.

I had not realized what a good politician you had become until I read the other weekend in my hometown paper your very complimentary remarks about me and your suggestion that I was unopposed as your successor because of my personal and professional credentials. That was so much more politic than saying there just aren't that many fools in this Association!

Twenty-one years ago, when I first joined the FMA, I could not have imagined being here tonight as we embark on a new year. No more than I could have imagined the challenges that confront our profession and our Association.

Despite that lack of imagination, let me make it very clear to each of you that I am honored to be here, but more importantly, that you are all here with me to share in whatever lies ahead.

Sharing with others has been an important part of my life and of the shaping of events in it that seem to have happened more by chance than by conscious plan. So you will understand where "I'm coming from," I'd like to briefly share some of these events with you and introduce some of the people who have had a hand in my being here tonight.

When I graduated from high school in Charlotte in 1951, the Korean War was just heating up, and I enlisted in the Air Force, with romantic visions of becoming a jet pilot.

Those visions went awry, however, when I failed the eye exam, and ended up serving four years as a B-29 radio operator. In 1959, I enrolled in pre-med at the University of North Carolina, and in 1963, after graduating from medical school, I started my internship in pediatrics at Gainesville, where I met Gerry Schiebler.

Gerry taught me three things:

First, how to be a caring physician.

Second, the importance of the political process.

And third, knowing what the votes are before going in.

In 1966, I began practice in Daytona Beach with Harry Gillis. I went to my attorney, Bill Loucks, to have a partnership agreement drawn up. There I met Beebe Shepherd and three months later, on October 28, 1966, Beebe and I were married.

The first couple we had dinner with after we returned from our honeymoon was Cici and Hyatt Brown. We then formed a supper club with several other couples through which we were able to share and broaden our interests, particularly in sports and politics.

I became active in the Volusia County Medical Society, particularly in the areas of FLAMPAC and legislation. I was named to the FLAMPAC Board and the state legislative committee, through which I found myself heavily involved with political campaigns and with incomparable campaigners like Hyatt Brown and Sam Bell.

It was a total surprise when Dr. Richard Hodes appointed me to the Board of Governors and most of you know the rest of the story.

Against that background, I would like to introduce a number of very special people to you now:

My family — Beebe — a politician in her own right — and a good one as multi-term chairman — or out in public I guess it's just chair — of the Volusia County School Board; son Jamie, with his wife, Gena; son Mark, sophomore at UNC; daughter Merri Beth, junior at Seabreeze High School.

My office staff — the best of the best — Pat Burt, P.N.P., and David Burt; Jean Brown and Dr. Bob Brown; Genny Cushing and Don Cushing; Judy Brown, secretary, and Chet Brown; Pat Walter and Dr. Bill Walter. Top Gun of Office Staffs.

And my friends — Cici and Hyatt Brown; Betty and Bill Loucks; Representative Sam Bell; Gloria and Bryant Byrd; George and Shirley Thompson; Karen and Ron Rees; Jim and Liz Surrat; VCMS members and spouses; Gloria Barkin.

Thank you for permitting me to share these very important people in my life with you and to publicly thank each of them, along with my many colleagues and untold others who have unselfishly helped me along the way, making this moment possible.

With the preface that I seek no interpretation from our friends in psychiatry, let me share with you a recurring dream I've had for many years. I am in college in the last few days before graduation. I need all of my courses to graduate, but in one course I have not attended a single lecture, taken a note, nor do I even own the textbook. Tomorrow is the final exam. At least six times I have had this dream and the apprehension is so real that each time I have awakened in a cold sweat.

Until tonight, I have never understood what that dream really meant.

Although I've surely tried to do my homework, I approach this year with apprehension. For the past five or six years, I have watched really competent and courageous people step into the breech to confront with the PLI, PRO, HMO, PIMCO, and any number of other strange sounding names. I have seen from near ground zero the toll that this job has taken on my friend, Jim Perry.

For 12 years, I have seen the hopes of our Legislative Committee, Board of Governors, and our very fine staff dashed in the halls of the Capitol and in the Supreme Court in Tallahassee.

I have seen the morale of our members reach an all-time low. I have seen excellent physicians quit practice solely because of the liability situation in which we find ourselves. I have had friends and fellow physicians ask me, "Why are you submitting yourself and your family to this nightmare?"

And I must confess that, after some particularly bad days, I've asked myself the same question.

The answer is one I share widely with people in this room and that is neatly captured in the old saying that "we make a living by what we get, but we make a life by what we give."

Can one person make a difference? I think it is possible if that person seeks out bright, hard-working people and motivates them to meet the challenges.

I have never entered into any contest that I felt I could not win. To this point in my life, I have never failed. There were times when I was a little nervous, particularly when I was in aircraft instrument training, but in more recent years I have picked up a point from our former Speaker of the House and Current Regent, Hyatt Brown, and when things look impossible, I just say, "It'll all work out."

I say that to you tonight regarding our professional liability insurance problem, and honestly believe that it is not wishful thinking. We are very close to a solution.

I think it will be a better solution than the one that our experience to date brings to mind in the story

told by Jerry Clower of that good 'ole boy, coon-hunter, John. Jerry allows as how John got himself up in the top of a tree trying to knock down an elusive coon for his fellow hunters on the ground, but when they came face to face in the upper limbs, found that the coon was actually a lynx. After John and that unhappy lynx had been going 'round and 'round for a while, John yelled down to his friends to shoot up into the tree.

They didn't want to shoot, they yelled back, because they might hit John instead of the lynx. "Shoot up here amongst us anyway," John yelled, "one of us has got to have some relief!"

I look for our State legislators to take some telling shots at the PLI problem, but with a clear target and an aim that's right on. Sam Bell has assured me personally, and each of you in a letter from him published in the July Journal of the FMA, that he will go to the wall to pass whatever the Academic Task Force recommends. Sam will do this, and he possesses the leadership qualities to attract broad support, but he will need our full commitment through contact and communication with our local representatives and senators.

We must also recommit ourselves and intensify our efforts on our Constitutional initiative. We are on target in getting the necessary signatures. The Auxiliary is doing outstanding work, for which they deserve praise and appreciation. We need to intensify our fund raising efforts which is in a very real way an investment in the future of health care in Florida, as well as the future of our individual practices. We need to continue to support the coalition through which we are seeing positive efforts in the business community.

Each of these steps is as basic as it is vital, and from this commitment flows the theme we will follow this year: "Back to Basics."

Let us never forget that caring for our patients is our basic mission.

We are going to put CARING back into medical care.

We are going to communicate better with patients and let them know we CARE ABOUT THEM AS PEOPLE.

We must always remember that there is a PERSON in that BODY. We need to take care of the person and not act so concerned about the money.

As we gaze into the future, we need to put behind us the search for easy answers or quick fixes. It's popular to talk about hiring P.R. firms to help our image. All the P.R. firms in the world can't do for us what we should be doing for ourselves — letting all with whom we deal know how much we care.

I pledge to you tonight my total effort to assure that there is two way communication between our leadership and our membership. We are going to the grass roots for ideas and support. Nothing angers me more than to hear our members refer to the FMA as "they". "They" is us! We Board members pay our premiums just like you do.

Let me say, too, that election to an office in this Association doesn't automatically confer a corner on the thought process. If you or any member have ideas as to how we can improve our lot, please share them. We need your help and thinking to do the best job we can do for you.

Let me turn for a moment, if I may, to the high risk physicians among us. I want you to know that I fully appreciate the terrible predicament in which you find yourselves.

Neurosurgeons, highly trained to do complex, life-saving procedures, yet unwilling to do so because of the ever-present threat of litigation.

Ob-Gyns, again highly trained, dedicated to sharing with couples the joy of a new life, but having to back away from those couples at a time that they need you most. Nothing tears at my heart more than to have a young mother tell me that she hesitates getting pregnant again for fear of not having a qualified obstetrician to deliver her baby.

To you, and others whose specialties are at peril, let me assure you of our awareness that you have been placed in an untenable position, and that we will not rest until we have freed you from this nightmare.

Let me repeat again that I truly believe we are very near to winning this battle. A window of opportunity has opened and we must not hesitate lest that window close. And we need not hesitate. On my office wall hang several quotes. The one I find most appropriate to this time says that, "on the plains of hesitation bleach the bones of countless millions who, at the dawn of victory, sat down to wait, and waiting died."

Thank you. I appreciate so much for your permitting me to serve this great organization. I pledge to you tonight that, with your help and your participation, I will do my best to see that we have a good year. Thank you, and God bless you.

REPORT A
of the Board of Governors

James B. Perry, M.D., Chairman
(Reference Committee No. I, page 1057)

HOUSE ACTION: ADOPTED

BOARD ACTIONS OF MAJOR IMPORTANCE

FMA COUNCILS AND COMMITTEES

COUNCIL ON SCIENTIFIC ACTIVITIES

The Annual Report of the major activities of the Council on Scientific Activities is included in this section of the Delegate Handbook. The Board of Governors has reviewed the Council's activities during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

1987 Annual Meeting: The Board established the format for the 1987 Annual Meeting, September 16-20, 1987, at the Diplomat Hotel in Hollywood, Florida. It is expected that twenty-seven specialty societies will offer scientific programs and up to 15 hours of AMA Category I credit may be earned through the joint-sponsorship of the Florida Medical Foundation Committee on Continuing Medical Education.

ACCME Continued Recognition: The Board enthusiastically received a report that the FMA Committee on Medical Education was awarded the maximum four-year continued recognition as the accreditor of intrastrate sponsors of continuing medical education. The Accreditation Council for Continuing Medical Education has completed a review of 38 state medical associations to determine their adherence to proper procedures and guidelines as accrediting bodies.

CME Accreditation Appeal Process: The Board approved a formal appeal process for hospitals and organizations which have received adverse actions on their application for accreditation as sponsors of continuing medical education which states:

> "As the result of any adverse decision on accreditation, the hospital or organization in question may submit a letter of appeal to the Chairman of the Council on Scientific Activities who shall allow representatives of the hospital or organization to appear before the Council at its next meeting. Should the hospital or organization not agree with the resulting decision of the Council, they shall have the opportunity to submit a written appeal to the Executive Committee of the Board of Governors where general counsel will be available. The decision of the Executive Committee shall be final. However, after a minimum of one year, a new application may be submitted."

FMA Mandatory CME Requirement: The Council reported to the Board that much confusion and concern has been expressed due to the fact that the Florida Medical Association continues its mandatory CME requirement with a three year reporting cycle while the Department of Professional Regulation and the Board of Medicine require physicians to earn CME credits biennially. The Council felt the FMA would better serve its members by requiring a reporting period in concert with physician relicensing requirements. The Council also recommended that members of the FMA should report their CME

credits directly to the FMA rather than to county medical societies, as is currently the procedure, so that a centralized CME recordkeeping system can be maintained.

RECOMMENDATION A-1
(Reference Committee No. I, page 1057)

HOUSE ACTION: NOT ADOPTED
(Substitute Resolution 87-29 was adopted in lieu of Recommendation A-1 and Resolution 87-29)

THAT THE HOUSE OF DELEGATES AMEND THE FMA MANDATORY CONTINUING MEDICAL EDUCATION REQUIREMENT FROM 150 HOURS EACH THREE-YEAR CYCLE WITH A MINIMUM OF 60 CATEGORY I HOURS OR ITS EQUIVALENT TO A NEW REQUIREMENT OF 40 HOURS OF CATEGORY I HOURS OR ITS EQUIVALENT BIENNIALLY; AND FURTHER, THAT MEMBERS REPORT DIRECTLY TO THE FMA WITH THE FIRST REPORTING PERIOD EFFECTIVE THE BIENNIUM BETWEEN JANUARY 1, 1988, TO DECEMBER 31, 1989.

JFMA Editor: The Board enthusiastically approved the President-elect's nomination of Remigio G. Lacsamana, M.D., Daytona Beach, for reappointment as Editor of the *Journal of the Florida Medical Association* for 1987-88. The Board also approved the following nominations for the JFMA Editorial Board:

Associate Editors
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
F. Norman Vickers, M.D.

Assistant Editors
Frank C. Coleman, M.D.
James K. Conn, M.D.
Kay K. Hanley, M.D.
Robert E. McCammon, M.D.
Gerold L. Schiebler, M.D. (From the Board)

Contributing Editors
Daniel B. Nunn, M.D.
Clyde M. Collins, M.D.
Richard J. Feinstein, M.D.
Edward Pedrero Jr., M.D., Ph.D.
E. Charlton Prather, M.D.
William M. Straight, M.D.
Pierre J. Bouis Jr., M.D.

Historical Editor
H. Frank Farmer, M.D., Ph.D.

Medical Economics Editor
Jacques Caldwell, M.D.

County Medical Society Bulletin Workshop: The Board approved a workshop for county medical society bulletin editors and managing editors to be held during 1987 prior to the FMA Annual Meeting.

State Medical Journal Advertising Bureau: The Board was pleased to receive a report on the increased advertising in the FMA Journal. The Journal reported an increase in national advertising revenue during the first half of 1987 compared with the same period in 1986. The total increase is $4,397.98 which is up 8.56 percent ($55,799.78 vs. $51,401.80). A dramatic change was seen in comparing June 1987 ($13,049.88) to June 1986 ($7,321.22) which was a 78.25 percent increase. The Board commended the Editor and the entire editorial staff for the continuing excellence of the Journal which has earned national recognition.

COUNCIL ON SPECIALTY MEDICINE

The Annual Report of the major activities of the Council on Specialty Medicine is included in this section of the Delegate's Handbook. The Board has reviewed the Council's activities during the past

Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

FMA Criteria Re Specialty Group Recognition: At the 1986 Annual Meeting, the House of Delegates asked that the Council on Specialty Medicine define the criteria and length and consequences of probation which should not exceed one year and report on its recommendations in respect to such criteria.

The House of Delegates in 1982 had approved the following specialty recognition criteria: "That under the category 'Probation', any deviation in excess of 10 percent from guideline I.H. and that any specialty group placed in the probationary category while retaining all rights of participation in deliberations of the Council, be denied the privilege of voting during the year of probation"; and "that a specialty group be terminated from the program if it does not satisfy the guidelines at the end of the probationary status provided, however, that the specialty group may reapply as a new specialty."

It was the considered opinion of the Council on Specialty Medicine that these decisions of the 1982 House continue with the exception of the 1986 House of Delegates amendment extending the deviation from 10 percent to 25 percent. Accordingly, the Council on Specialty Medicine reiterated the criteria by which a specialty group may be placed on probation.

1. Excessive numbers of members who are not concomitantly members of FMA (more than 25 percent);

2. Failure to attend two-thirds of the scheduled meetings of the Council over a two-year period;

3. Failure to provide and/or sponsor a scientific session at the annual meeting of the FMA at least once every three years;

4. Failure to properly apply for re-recognition every two years.

As declared by the House of Delegates, probation may not exceed one year. During that year the specialty group may not vote on issues before the Council. The Council interpreted the loss of voting privileges to include loss of voting privileges in the House of Delegates during the probationary period. However, a specialty group on probation may participate in all deliberations and debate of the Council and, in the opinion of the Council, may be present on the Floor of the House as a guest. It may not participate in House debate. If at the end of the one year probation a specialty group has not completely satisfied all criteria of recognition, the Council on Specialty Medicine recommends that the group's association and participation with the Council on Specialty Medicine be terminated.

RECOMMENDATION A-2
(Reference Committee No. I, page 1057)

HOUSE ACTION: ADOPTED

THAT THE HOUSE OF DELEGATES APPROVE THE RECOMMENDATION THAT THE FMA REAFFIRM ITS POLICY THAT IF AT THE END OF ONE YEAR PROBATION A SPECIALTY GROUP HAS NOT COMPLETELY SATISFIED ALL CRITERIA OF RECOGNITION, THEN ITS ASSOCIATION AND PARTICIPATION WITH THE COUNCIL ON SPECIALTY MEDICINE SHALL BE TERMINATED; AND THAT THE CHAIRMAN OF THE COUNCIL ON SPECIALTY MEDICINE NOTIFY THE TERMINATED GROUP IN WRITING THE SPECIFIC REASONS FOR TERMINATION AND INFORM THE GROUP THAT IT MAY REAPPLY FOR SPECIALTY RECOGNITION AS REQUIRED OF ANY NEW SPECIALTY GROUP SEEKING RECOGNITION BY THE FMA.

Specialty Group Recognition Program: The Board received a report from the Council that eighteen specialty groups were up for recognition during the current FMA year. The Board took action on two of these under the 25% variance criteria from the requirement of 100% FMA membership. The remaining sixteen specialty group applications have been received and their adherence to specialty recognition criteria is under review. A recommendation pertaining to their continuing recognition is contained in a supplementary report of the Council.

RECOMMENDATION A-3
(Reference Committee No. I, page 1057)

HOUSE ACTION: ADOPTED

THAT THE HOUSE OF DELEGATES APPROVE CONTINUING RECOGNITION OF THE FOLLOWING SPECIALTY GROUPS WHO HAVE MET THE CRITERIA ESTABLISHED BY THE FMA HOUSE OF DELEGATES FOR RECOGNITION BY THE ASSOCIATION:

Florida Academy of Family Physicians
Florida Chapter, American College of Surgeons

Termination of Recognition: At the 1982 FMA Annual Meeting, the House of Delegates approved Recommendation No. A-3 that modified the criteria and guidelines of the FMA program of specialty group recognition. One of the approved guidelines reads: "that a specialty group be terminated from the program if it does not satisfy the guidelines at the end of the probationary status provided, however, that the specialty group may reapply as a new specialty." The Florida Association of Nuclear Physicians was placed on probation in 1985 and did not reapply for continuing recognition during the 1985-86 FMA year. At the 1986 FMA Annual Meeting, the House of Delegates voted to continue this specialty group on probation. The Florida State Surgical Division, International College of Surgeons was placed on probation by the FMA House of Delegates at the 1986 Annual Meeting for not having submitted an application during the year it was due to apply for continuing specialty recognition. Neither the Florida Association of Nuclear Physicians nor the Florida Surgical Division, International College of Surgeons, submitted applications in order to be considered for specialty recognition by the May 31, 1987, deadline set by the Council on Specialty Medicine. Further, neither society has had a representative attend the Council on Specialty Medicine meetings this current FMA year.

RECOMMENDATION A-4
(Reference Committee No. I, page 1057)

HOUSE ACTION: ADOPTED

THAT THE HOUSE OF DELEGATES TERMINATE FROM THE PROGRAM OF SPECIALTY RECOGNITION THE FLORIDA STATE SURGICAL DIVISION, INTERNATIONAL COLLEGE OF SURGEONS, AND THE FLORIDA ASSOCIATION OF NUCLEAR PHYSICIANS, PROVIDED THAT THE SPECIALTY GROUPS MAY REAPPLY AS NEW SPECIALTIES.

Specialty Charge Survey: The Board received as information a report that the Council on Specialty Medicine would be involved in the review of data obtained by the Hospital Cost Containment Board in a survey of physicians and their charges according to specialty classification of the physicians surveyed. This activity is being undertaken in concert with the FMA Technical Assistance Panel of the Council on Medical Economics.

Ad Hoc Committees: The Board received for information a report that the Council on Specialty Medicine has established two ad hoc working groups within the Council to concentrate on the prescribing of drugs by non-physicians and the encroachments on the practice of medicine by various other allied health personnel.

Relative Values of Medical Mishaps and Indigent Care: The Board encouraged the Council on Specialty Medicine to pursue the concepts introduced to it by the President. These concepts include the development of a relative value for medical mishaps and the relative value of indigent care, i.e., the amount of charges physicians would be willing to receive on a relative basis for the provision of indigent health care.

RECOMMENDATION A-5
(Reference Committee No. I, page 1057)

HOUSE ACTION: ADOPTED AS AMENDED

USE OF ANIMALS IN MEDICAL RESEARCH: THE BOARD APPROVED A RESOLUTION ON THE USE OF ANIMALS IN MEDICAL RESEARCH WHICH READS:

"Whereas, the Florida Medical Association supports the National and International initiatives in the humane use of animals in medical research; and whereas, the medical colleges in the State of Florida also participate in these national and international scientific and research activities; and whereas, the Florida Medical Association also supports the colleges of medicine in the State of Florida in the humane use of animals in medical research; and whereas, the continued access to abandoned animals taken into custody by the county pounds or animal control units in an important source of suitable animal subjects for use in research; and whereas, the Florida Medical Association supports the use of animals in research for the following reasons:

1. The use of a living system in research is essential both to research and education and is vital to the development of drugs, medical devices and new technology to aid in promoting health and the treatment of disease;
2. The researchers in the colleges of medicine exercise the greatest care and concern for the animals' comfort and welfare. Research animals are treated in a humane fashion and anesthetics, analgesics and tranquilizers are used whenever needed to prevent suffering;
3. Pound animals abandoned by their owners and unwanted by others fill a great need in the research field. It is unnecessary to breed new animals to be used in research when many thousands of unclaimed, abandoned animals are being destroyed in the State of Florida;
4. Replacing pound animals with animals purchased from breeders would greatly increase the expense of developing new drugs and technology. The use of domesticated animals in animal research is safer and easier for researchers and their assistants participating in animal research; therefore be it

RESOLVED, That the Florida Medical Association supports a policy which would endorse the colleges of medicine within the State of Florida to continue to make humane use of animals in research and to have access to pound animals in support of this important and necessary research; and be it further

RESOLVED, That the citizens of the State of Florida be encouraged to maintain an enlightened attitude toward science and research; and be it further

RESOLVED, That copies of this resolution be made public and available to all appropriate parties; and be it further

RESOLVED, That this resolution be referred to the Council on Legislation and, if legislation is introduced in the Florida Legislature that is not in compliance with the principles contained in this recommendation, that such legislation be opposed."

REPORT B
of the Board of Governors

James B. Perry, M.D., Chairman
(Reference Committee No. II, page 1059)

HOUSE ACTION: ADOPTED AS AMENDED

BOARD ACTIONS OF MAJOR IMPORTANCE

FMA COUNCILS AND COMMITTEES

COUNCIL ON MEDICAL SERVICES

The Annual Report of the major activities of the Council on Medical Services is included in this section of the Delegate's Handbook. The Board of Governors has reviewed the Council's activities during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

Medicaid/Generic Drugs: The Board took the position that any drug manufacturer supplying generic drugs for use in the Medicaid Program as well as those drugs used by the general public should be required to furnish documentation that each drug supplied is truly equivalent to the corresponding brand name drug in formulation, efficacy and safety.

Trauma Center Legislation: The Board determined that the FMA would sponsor in the 1987 Florida Legislature a strong trauma bill which incorporates the concepts of designation and regionalization with a limitation of the number of designated trauma centers in each region and which limits the liability of trauma surgeons and gives consideration to infants and children.

Certification Program in School Nursing: The Board approved in principle the Florida School Health Association's proposed program of certification in health/school nursing. The Florida School Health Association would consult with the School Health Medical Advisory Committee as the program undergoes further development and refinement.

Florida Foundation for School Health: The Board appointed Joseph T. Ostroski, M.D., Miami, to the Florida Foundation for School Health.

Additional Funding for School Health Services: The Board supported the concept of additional school health services and requested the Council on Medical Services and the Committee on School Health to develop various options on how such additional services might be implemented and a fiscal note of each option and emphasize involvement of the private sector. The Committee on School Health and the Council on Medical Services should consider involving the Child Health Policy Institute of the State University System in developing the various options.

Reduced Fee School Examinations: The Board agreed that the Florida Medical Association broaden the application of the third resolve of FMA Resolution 86A-26 (Reduced Fee School Examinations) adopted by the House of Delegates in September, 1986, (Appendix B-1) to afford greater liability protection to physicians who conduct pre-school physical examinations free of charge, as well as those who perform participation (athletic) examinations; and further, that the FMA consider recommending to these physicians that they enter outside provider service contracts with the Department of Health and Rehabilitative Services in order to gain protection under the State's Sovereign Immunity.

Recognition of Physicians Who Donate Time for School and Sports Physicals: The Board approved that the Florida Medical Association, upon the Annual recommendation of the county medical societies, award certificates of volunteer participation to those FMA members who, during the previous school year, provided school entry and athletic physical examinations free of charge; further, that this policy also apply to physicians who donate their time for "Special Olympics" and similar programs; and further, that these physicians be further recognized through publication of their names in a special pamphlet to be distributed at the Annual Meeting each year.

Public School Nursing Service Feasibility Study: The Board endorsed the enhancement and improvement of public school nursing in Florida and directed the FMA to advise the Legislature that it believes that any of the three models (Appendix B-2) developed in conjunction with the 1986-87 Public School Nursing Service study or some combination of these models, merit serious consideration.

Federal Funds for Drug Education: Under new Federal legislation, the Department of Education will receive $4 million for use in the K-12 curriculum, while $2 million will go to the Governor's Office. Since there are many government and private agencies involved in substance abuse education, the Board concurs that extreme care should be exercised in determining when and how these funds are spent in order to assure maximum effectiveness.

RECOMMENDATION B-1

That the House of Delegates adopt the following resolution regarding Federal funding for drug education.

"WHEREAS, APPROXIMATELY $6 MILLION IN FEDERAL FUNDS IS CURRENTLY BEING DISTRIBUTED TO THE FLORIDA DEPARTMENT OF EDUCATION AND THE OFFICE OF THE GOVERNOR FOR SUBSTANCE ABUSE INTERVENTION AND EDUATION; AND

WHEREAS, THERE ARE EXISTING FEDERAL AND STATE FUNDED AGENCIES WITH POSSIBLE OVERLAPPING RESOURCES AND SERVICES; THEREFORE BE IT

RESOLVED, THAT A SPECIFIC NEEDS ASSESSMENT WITH REGARD TO SUBSTANCE ABUSE EDUCATION BE CONDUCTED SO AS TO APPROPRIATELY DELIVER NECESSARY FEDERAL MONIES AND ALLOCATE EDUCATION TIME TO THIS PROJECT; AND BE IT FURTHER

RESOLVED, THAT THE GOVERNOR'S OFFICE AND THE COMMISSIONER OF EDUCATION IN-

VESTIGATE EXISTING RESOURCES TO AVOID DUPLICATION OF EFFORTS, AND THAT THEY USE THESE FUNDS TO MAXIMUM ADVANTAGE.''

County Health Unit/County Medical Society Relations: The Board agreed to encourage county medical societies to invite their local county health officers to all meetings of their governing boards.

Boy and Girl Scouts: The Board agreed to encourage county societies to poll their memberships in a program to construct and maintain a roster of physicians who are willing to assist boy and girl scouts who are pursuing health-related merit badges, and another roster of physicians who agree to serve as advisors to medically-oriented explorer scouting posts.

The Council, through its Committee on Public Health, has investigated ways that young men and women in scouting might be assisted in their health-related merit badge program and other activities. Feedback from scout leaders has been very positive.

Commercial Sex Establishments: The Board endorsed the efforts of the State, Local and Federal authorities to control public reservoirs of infection as represented by commercial sex establishments and agreed to educate the public regarding the transmission of Acquired Immune Deficiency Syndrome and other sexually transmitted diseases.

Board of Regents Immunization Policy: The Board commended Charles Reed, Chancellor, and the Florida Board of Regents for developing measles and rubella immunization requirements as a prerequisite to matriculation or registration in the State University System of Florida.

Continuing Education for Dispensers of Drugs: The Board referred to the Committee on Medical Education for consideration a recommendation for the development of a CME course to satisfy the CME requirement for dispensing physicians in order to meet the requirements of Section 465.0276 (1)(c), F.S.

International Medical Centers (IMC): The Board agreed to take an active leadership role with affected county medical societies to mobilize health care resources at the local level to meet the health care needs of persons, especially the elderly, who find themselves disenrolled from International Medical Centers (IMC) and other prepaid plans. The FMA will seek to meet with the Assistant Secretary for Health of the U.S. Department of Health and Human Services, the Director of the U.S. Health Care Financing Administration, the Florida Insurance Commissioner, the Secretary of the Florida Department of Health and Rehabilitative Services and other appropriate entities to find an immediate solution to the urgent situation caused by IMC's collapse.

Medicaid and Medicare HMOs: The Board authorized the Florida Medical Association to seek, through the Department of Health and Rehabilitative Services, Insurance Commissioner Bill Gunter and other appropriate authorities, to assure that Medicare and/or Medicaid Health Maintenance Organizations (HMOs) or other prepaid health programs should not fall below or otherwise be exempted from the laws pertaining to HMOs and prepaid health programs, particularly as they relate to quality care and financial stability.

Acquired Immune Deficiency Syndrome (AIDS) and Blood Transfusions: The Board considered a recommendation from the Council that the FMA adopt a consensus statement regarding Acquired Immune Deficiency Syndrome (AIDS) and blood transfusions in the wake of the Center for Disease Control (CDC) important advisory published March 20, 1987. A working group convened by acting state health officer E. Charlton Prather, M.D. and consisting of representatives of the FMA, Florida Osteopathic Medical Association, the Florida Association of Blood Banks and the Florida Hospital Association developed the statement.

RECOMMENDATION B-2

That the House of Delegates endorse the following statement on Acquired Immune Deficiency Syndrome (AIDS) and blood transfusions:

''THE CENTERS FOR DISEASE CONTROL HAS REPORTED IN THE MARCH 20, 1987, ISSUE OF THE *MORBIDITY AND MORTALITY WEEKLY REPORT* THAT IN A STUDY OF 204 LEUKEMIA PATIENTS, 16, OR 8 PERCENT, WERE SEROPOSITIVE FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV). THE 16 PATIENTS RECEIVED A MEAN OF 27 UNITS OF PACKED RED CELLS AND 137 UNITS OF PLATELETS BETWEEN 1978-1985. OTHER CASE REPORTS HAVE INDICATED AN ASSOCIATION BE-

TWEEN HIV INFECTION AND MULTIPLE TRANSFUSIONS. ALTHOUGH THE EXPECTED PREVALENCE OF TRANSFUSION ASSOCIATED WITH HIV INFECTION IS LOW, IT IS RECOMMENDED THAT PERSONS WHO HAVE RECEIVED BLOOD TRANSFUSIONS BETWEEN MAY 1, 1985, AND JANUARY 1, 1987, SHOULD BE EVALUATED AS TO WHETHER THEY SHOULD BE TESTED FOR HIV ANTIBODY. SINCE MAY 1985, ALL BLOOD DONATIONS HAVE BEEN SCREENED FOR ANTIBODY AND CONTAMINATED BLOOD IS DISCARDED.

THE CDC ESTIMATES THAT APPROXIMATELY 18 MILLION PEOPLE RECEIVED BLOOD TRANSFUSIONS BETWEEN 1978-1985 AND THAT 12,000 PERSONS MAY BE INFECTED AS A RESULT OF TRANSFUSIONS OR THROUGH CONTACT WITH AN INFECTED BLOOD RECIPIENT. IN FLORIDA, APPROXIMATELY 450 PERSONS MAY HAVE TRANSFUSION RELATED HIV INFECTION. THE RISK FOR INFECTION MAY INCREASE IF THE PATIENT RECEIVED MULTIPLE TRANSFUSIONS AND IF THE BLOOD WAS DONATED IN AN AREA WITH A HIGH INCIDENCE OF AIDS. THE MAJORITY OF PERSONS WITH HIV INFECTIONS ARE ASYMPTOMATIC (50-70 PERCENT) AND CAPABLE OF TRANSMITTING THE VIRUS THROUGH SEXUAL CONTACT. THEREFORE, PHYSICIANS SHOULD CONSIDER OFFERING THE ANTIBODY TEST TO PERSONS WHO RECEIVED TRANSFUSIONS AND THEIR SEXUAL PARTNERS.

THE PHYSICIAN SHOULD EVALUATE THE PATIENT'S RISK STATUS BY DETERMINING HOW MANY UNITS WERE TRANSFUSED, THE GEOGRAPHIC LOCATION OF THE TRANSFUSION — HIGH PREVALENCE AREAS FOR CONTAMINATED BLOOD ARE NEW YORK, CALIFORNIA, SOUTH FLORIDA AND NEW JERSEY — AND WHAT OTHER RISK FACTORS THE PATIENT MAY HAVE THAT COULD CAUSE HIV INFECTION, I.E., HOMOSEXUAL, IV DRUG USER, HEMOPHILIAC. IF THE PATIENT PRESENTS A RISK FOR HIV INFECTION, THE PHYSICIAN SHOULD PROVIDE COUNSELING ON THE INTERPRETATION OF THE TEST AND REDUCTION OF UNSAFE BEHAVIORS. THE PATIENT SHOULD BE AWARE THAT THE TEST ONLY DETECTS ANTIBODY AND WILL NOT DETERMINE IF THE PATIENT HAS OR WILL GET AIDS. ADDITIONALLY, A NEGATIVE TEST DOES NOT INDICATE IMMUNITY TO THE VIRUS IF THE PATIENT HAS A HISTORY OF POSSIBLE VIRUS EXPOSURE. ACCORDING TO CDC, TESTING AND COUNSELING IS PARTICULARLY IMPORTANT IF THE PATIENT IS SEXUALLY ACTIVE. COUNSELING SHOULD BE PROVIDED FOR ALL SEROPOSITIVE PATIENTS. COUNTY PUBLIC HEALTH UNITS, THE "ALTERNATIVE TEST SITES," COMMUNITY SUPPORT GROUPS (AIDS SERVICE ORGANIZATIONS), INFECTION CONTROL PRACTITIONERS AND POSSIBLY OTHERS CAN PROVIDE OR ASSIST WITH THE NEEDED COUNSELING. ALL SEROPOSITIVE PERSONS SHOULD BE EVALUATED FOR SIGNS AND SYMPTOMS OF AIDS OR RELATED CONDITIONS.

SEVERAL SEROLOGIC TESTS ARE AVAILABLE TO DETERMINE HIV ANTIBODY. THE MOST COMMONLY USED TESTS ARE THE IMMUNOSORBENT ASSAY (ELISA OR EIA), AND WESTERN BLOT. ACCORDING TO CDC, 'SINCE THE OVERALL PREVALENCE OF INFECTION IN TRANSFUSION RECIPIENTS IS EXPECTED TO BE LOW, THE POSITIVE PREDICTIVE VALUE OF EI SCREENING TESTS FOR HIV ANTIBODY WILL BE MUCH LOWER THAN THAT SEEN WHEN TESTING HIGH-RISK POPULATIONS.' THEREFORE, ALL TRANSFUSION RECIPIENTS WITH A POSITIVE EIA SHOULD ALSO HAVE THEIR SERUM TESTED BY A SECOND METHOD (WESTERN BLOT ASSAY, IMMUNOFLUORESCENCE ASSAY) BEFORE THEY ARE INFORMED OF THEIR TEST RESULT. THE SEROCONVERSION RATE FROM EXPOSURE TO VIRUS TO ANTIBODY DETECTION BY THE TEST IS TWO TO SIX MONTHS."

Education of Acquired Immune Deficiency Syndrome (AIDS): The Board approved the acceleration of professional and public education about Acquired Immune Deficiency Syndrome (AIDS) and agreed to explore with the College of Public Health at the University of South Florida and other interested institutions appropriate mechanisms to jointly provide educational programs about AIDS to health professionals and the general public.

Adult Immunizations: The Board recognized that the importance of adult immunizations often is overlooked in campaigns to immunize children, and supported adult immunizations with special attention to influenza, pneumonia, diphtheria, measles, tetanus, rubella, pneumococcus and hepatitis.

Health Warnings on Alcoholic Beverage Containers: The Board authorized the FMA to continue to support and/or promote legislation relating to health warning labeling on alcoholic beverage containers. Local county medical societies would be encouraged to become involved in local community efforts to educate the public on the hazards of alcohol misuse, such as local ordinances requiring warning posters to be exhibited in retail establishments where alcoholic beverages are sold.

The Board commended Mr. David Clearly of Lake County Citizens Committee for Health Warnings on Alcoholic Beverages for his efforts in promoting health warning label legislation.

Public Health's Role in Medicine: The Board approved making 1989 a special year of celebration for public health and that public health's role in medicine be considered by the 1988-89 FMA President as the theme for the 1989 Annual Meeting. The FMA's role in creating the constitutional and statutory provisions that establish a State Organized Public Health System will be appropriately recognized and made known to the public throughout 1989.

AIDS Discrimination: The Board opposed discrimination by drug and alcohol rehabilitation centers against patients who have Acquired Immune Deficiency Syndrome (AIDS) or who are HIV positive. The FMA will urge the Alcohol and Drug Abuse Program Office of the Florida Department of Health and Rehabilitative Services to prepare licensure rules that prohibit such discrimination in the admission of patients for treatment.

Drug Abuse in Athletes/Anabolic Steroids and Human Growth Hormones: The Board endorsed Report B (I-86) of the American Medical Association Council on Scientific Affairs, Subject: "Drug Abuse in Athletes: Anabolic Steroids and Human Growth Hormones" and agreed that Anabolic Steroids and Human Growth Hormones be regarded as drugs of abuse and be added to the list of abusable drugs within high school education programs. (Appendix B-3)

Application for National Institute on Drug Abuse Grant: The Board directed the FMA to apply to the National Institute on Drug Abuse for a grant for an educational program to improve the quality and breadth of knowledge of physicians in recognizing chemical dependency in their practice and invite the American Medical Association to co-sponsor this project.

National Invitational Conference on Prescription Drug Abuse: The Board approved FMA co-sponsorship of the 1988 National Invitational Conference on Prescription Drug Abuse.

HTLV-III vs. HIV: The Board agreed that in order to conform with what has become conventional usage, the term "Human Immunodeficiency Virus (HIV)" should be used in official documents and communications in place of "HTLV-III" and related viruses.

Health Policy Agenda/Funding for Biomedical Research: The Board supported increased Federal funding for basic and applied biomedical research. This position will be communicated to U.S. Senator Lawton Chiles, Chairman of the Subcommittee on Labor, Health and Human Services, Education and Related Agencies of the Senate Appropriations Committee and to U.S. Rep. William H. Natcher, Chairman of the Subcommittee on Labor, Health and Human Services, Education and Related Agencies of the House Appropriations Committee.

Ad Hoc Group for Medical Research Funding: The Board authorized the FMA to support and consider becoming a member of the Ad Hoc Group for Medical Research funding. (Appendix B-4)

REPORT C of the Board of Governors

James B. Perry, M.D., Chairman
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

On behalf of the Board of Governors, your Chairman is highly pleased to submit this report to the House of Delegates regarding the broad scope of activities that have been undertaken by your Board and the Association's Councils and Committees during the past year.

It has been a year of great challenge as we have diligently focused our efforts, including a large part of the Association's financial and staff resources, on resolution of the continuing professional liability crisis, the most pervasive problem facing the majority of physicians. A comprehensive report on the FMA's professional liability activities is included in subsequent sections of this report to the House of

Delegates on the Association's major activities in 1986-87.

Despite the professional liability problem, your Board has endeavored to address the many other challenges facing our profession in a rapidly changing health care delivery environment. As you study and deliberate the reports and recommendations of the Association's councils and committees and the Association's short and long-term priorities included in the delegates handbook, I hope that you will agree that your Association is effectively working to address the important health issues of concern to the membership and the citizens of Florida.

As your Chairman, I have attempted during the past year to foster, in every way possible, a rekindling of the vital essence of medicine, taking care of the sick and injured and medical ethics. In every forum I have deplored the decimating effects of the PLI crisis, excessive government control and ill-conceived health care delivery schemes on the quality and access to health care, as well as the debilitating effect on the noble ideals that have made ours the finest and most caring health care system in the world.

During the past year we have worked to continue to build on the foundations for a new beginning and direction for the FMA so effectively begun and strengthened by my able predecessors Dr. Frank Coleman and Dr. Luis Perez. Their greatest hope, as is mine, is the unity of our profession. These are indeed difficult times and the single most important determinant of our success in meeting the challenges we face is our ability to speak and act as one voice. Your Chairman is honored for having had the opportunity of working with the many dedicated physicians who have actively served on the Association's councils and committees during the past year. They have given freely of their time, energies and talents in behalf of their colleagues and their patients.

I would like to extend special recognition to Mrs. Susan Marks and the FMA Auxiliary for their continuing exemplary efforts in behalf of the FMA during the past year. The expert and determined direction that the Auxiliary has provided to the FMA's Constitutional Amendment signature petition drive is testimony to the vital importance of the Auxiliary to the FMA's goals and objectives.

There is no adequate way to express my gratitude to those dedicated men and women with whom it has been my personal privilege and honor to serve on the Board of Governors. Each of your Board members have given generously of their time and talents and have always kept the best interest of all physicians and the betterment of health care uppermost in their thoughts and actions during this difficult year:

James G. White, M.D., President-Elect Ormond Beach
Kay K. Hanley, M.D., Vice President Clearwater
Henry M. Yonge, M.D., Secretary Pensacola
Yank D. Coble Jr., M.D., Treasurer Jacksonville
Guy T. Selander, M.D., Speaker of House Jacksonville
Luis M. Perez, M.D., IPP-88 Sanford
Frank C. Coleman, M.D., PP-87 Tampa
Paul A. Flaten, M.D., AL-87 Ft. Lauderdale
Gerold L. Schiebler, M.D., A-90 Gainesville
Calvin W. Martin, M.D., B-87 Arcadia
Dick L. Van Eldik, M.D., C-89 Lake Worth
A. Frederick Schild, M.D., D-88 Miami
Joseph C. Von Thron, M.D., AMA Del-87 Cocoa Beach
J. Lee Dockery, M.D., DHRS-87 Gainesville
Margaret C. S. Skinner, M.D., SBME-87 Miami
Jane A. Daniel, Med. Student Rep.-87 Miami
Keith McManus, M.D., Res-88 Orlando

To my successor, Dr. Jim White, I extend my best wishes that his year as President will be a deeply rewarding experience, as mine has been. With the level of leadership in Florida medicine and the many dedicated physicians who give of their time and talents in behalf of their colleagues, he can only succeed.

MAJOR ACTIVITIES

1987 Annual Meeting: The Board established the format for the 1987 FMA Annual Meeting at the Diplomat Hotel, Hollywood, Florida, September 16-20, 1987, and approved the scientific programs which will allow physicians to earn up to 20 hours in CME credit. (See also Board Report A re: FMA Annual Meeting.)

1987 FMA Leadership Conference: The 1987 Leadership Conference of the Florida Medical Association (FMA) was held March 20-22 at the Lincoln Hotel at Urban Centre, Tampa.

A distinguished roster of speakers, including officials of the American Medical Association, Florida state legislators, Florida judicial and legal representatives and leaders in the Florida Medical Association, addressed current national and state problems during the conference.

Physicians were offered a total of eight seminars from which to choose in their effort to enhance their own leadership potential and educational level.

State legislators repeatedly stressed the problems stemming from Florida's rapid growth and pledged to seek solutions. Said House Speaker Jon Mills, D-Gainesville, "It is the best of times and the worst of times for Florida," adding that the state faces needed improvements which, including a constitutionally forbidden state debt, would total $50 million in cost. Mills told the assembled physicians that unless public officials and citizens commit themselves to a program of quality, the state can send a message to other areas of the U.S. that it will remain economically mediocre. "Florida's tax system is one of the least effective in the nation, depending primarily on the five percent sales tax," he said. "But it doesn't grow and it isn't stable."

State Rep. Alzo J. Reddick, D-Tampa, a chief sponsor of legislation dealing with expanded health care for the indigent, made a plea for strong medical support. "Society is ultimately judged on how it treats the unfortunate," he said. "We are known for our number one climate; I sincerely hope we also will soon be portrayed as having a number one climate for indigent health care."

State Rep. David Thomas, R-Englewood (and the House's only medical doctor), also expressed solid support for indigent health care legislation, warning that failure to improve their health care will cause loss of federal support money.

W. Scott Wilber, assistant director of the AMA's Department of Congressional Relations, said that DRG legislation proposed in President Reagan's budget (affecting radiologists, anesthesiologists and pathologists) is almost certain to be defeated. He said Congress is expected to take little or no action during the next two years on resolving the nation's tort-liability insurance problem, citing the fact that the new chairman of the Commerce Committee, U.S. Sen. Ernest F. Hollings, D-South Carolina, is a trial attorney.

In the Speaker Training Workshop, Judy Wallace, associate professor at the University of Miami School of Communications, provided advice on improving physician skills in television interviews.

Don Ranley, Ph.D., professor of journalism at the University of Missouri, counselled seminar participants in a writing workshop.

Howard L. Lang, M.D., chairman of the AMA Governing Council of the Hospital Medical Staffs Section, warned that major reimbursement changes in Medicare and other governmental programs are expected to occur within the next few years, so physicians are advised to exercise self-governance in order to maintain the patient's advocate. He said hospital medical staffs should have their own legal counsel, separate from the hospital.

FMA Vice President Kay K. Hanley, M.D., told those attending the leadership Skills Seminar for Women Physicians that women are becoming increasingly involved in the FMA's leadership and in county medical societies and that more women physicians than ever are now available to be involved.

Circuit Court Judge A.C. Soud, Jr., of Jacksonville, a lecturer for the legal-judicial seminar, advised physicians called as witnesses in court trials to avoid sophisticated medical terms, use layman's language and avoid any terms which evoke fear.

Nancy W. Dickey, M.D., a Richmond, Texas, family physician who serves as one of seven practicing physicians on the AMA Council on Ethics and Judicial Affairs, told the group, "Doctors lose sleep over a lot of decisions they make over the years. The principles and council interpretations are accepted principles of ethics for most bodies of organized medicine so that when doctors have questions of such bodies, that information (recommendations on action and guidelines) comes from us." She said the hardest recommendation written by the council was that on withholding life support.

Greg Louganis, one of the nation's best-known Olympic diving champions and unmatched in his class, showed movies of his diving activities and explained why he is attempting to serve as a role model for young people to guard against abuse of drugs and alcohol.

The 1987 Leadership Conference was one of the most successful ever held. It opened new vistas in care of patients, the ethics of medical care and the problems of government, while offering excellent reports on why it is vital for the medical profession to take more interest and become more active in the governmental and political field.

FMA Priorities 1986-87: The Board approved the Association priorities for 1986-87. The status of the Association's activities in implementing the priorities is reflected throughout the Delegates Handbook. Additional information will be included as an additional report from the Board in the Delegates Packet.

Awards: The Board voted to continue the following FMA awards for 1987:

Excellence in Medical Journalism
Medical Speakers Awards
Medical Malpractice Prevention Award
Harold S. Strasser, M.D., Good Samaritan Award
Distinguished Layman Award

A.H. Robins Award: The Board reviewed nominations received from county medical societies and selected the recipient of the 1987 A.H. Robins Award "For Outstanding Community Service by a Physician." This award will be presented at the first meeting of the House of Delegates on September 17, 1987.

Good Samaritan Award: The Board selected an outstanding physician as recipient of the 1987 Harold S. Strasser, M.D., Good Samaritan Award for humanitarian acts above and beyond the high standard of conduct normally expected of physicians.

Certificate of Merit: The Board selected an outstanding physician for nomination to the House of Delegates to receive the Certificate of Merit for 1987 (the Association's highest honor of achievement). This nomination will be included in the Delegates' Packets for approval by the House of Delegates.

Certificate of Appreciation: The Board selected a physician to be nominated to the House of Delegates as recipient of the 1987 Certificate of Appreciation. This nomination will be included in the Delegates' Packets for approval by the House of Delegates.

Distinguished Layman Award: The Board of Governors selected two outstanding individuals to receive the 1987 Distinguished Layman Awards. The appropriate citations, along with the criteria for the award, will be included in the Delegates Packets. This award will be presented at the first meeting of the House of Delegates.

Nominations

Judicial Council: In Compliance with the FMA Bylaws, the Board of Governors has considered nominations for term expiring on the Judicial Council in 1987.

Dr. Joe Davis, District D member and current Chairman of the Council, has served two consecutive five-year terms and therefore is not eligible for re-election. The Board commended Dr. Davis for his many years of service and contributions to the activities of the Council and for his outstanding leadership as its Chairman.

RECOMMENDATION C-1
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

THAT THE HOUSE OF DELEGATES APPROVE THE NOMINATION OF JOHN O. BROWN, M.D., OF MIAMI FOR ELECTION AS THE DISTRICT D MEMBER OF THE JUDICIAL COUNCIL FOR A FIVE-YEAR TERM.

Committee on Membership and Discipline: In compliance with the FMA Bylaws, the Board of Governors considered nominations for terms expiring in 1987 on the Committee on Membership and Discipline.

RECOMMENDATION C-2
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING NOMINATIONS FOR ELECTION TO THE COMMITTEE ON MEMBERSHIP AND DISCIPLINE FOR THE TERMS INDICATED:

District	Nominees
1	James T. Cook III, M.D.
2	Robert P. Johnson, M.D.
3	Hugh A. Carithers, M.D.
4	Craig Raby, M.D.
	H.S.B. Treloar, M.D.
5	Frederick Weigand, M.D.
6	Michael J. Lukowski, M.D.
7	Linus W. Hewit, M.D.
8	William E. Hale, M.D.
9	David B. Johnson, M.D.
10	William Allen Boyce, M.D.
11	David Tingle, M.D.
12	V. A. Marks, M.D.
13	Richard C. Rehmeyer, M.D.
14	Lee A. Fischer, M.D.
15	Stanley S. Goodman, M.D.
16	William C. Hartley, M.D.
17	Alan S. Graubert, M.D.
18	Everett Shocket, M.D.
19	John D. White, M.D.

FMA Finances: A comprehensive report from the FMA Treasurer on the status of the Association's finances will be included in the Delegates' Packets and presented by the Treasurer to Reference Committee III. The following is a summary report and recommendations regarding the FMA's finances submitted by the Board for consideration by the House.

Income/Expenditures, 1986: The Association had a total income of $3,981,226 during 1986 from all sources including the following:

Dues and fees	2,694,355
FMA *Journal*	127,367
Directory and other publications	94,461
Technical Exhibits	16,800
Interest and Dividends	210,046
Special Services	76,235
Special Contracts	756,917
GTE/MINET Program	5,045
Total Income	$3,981,226

Total expenditures during the year were $3,960,398 in the following categories:

General Activities:	1,528,550
Contract Services:	170,154
Administration:	547,431
Personnel:	1,610,774
Corporate Fund:	103,489
Total Expenditures:	$3,960,398

1987 Budget: The Board approved the proposed budget for 1987 with total anticipated income and expenditures of $4,867,000.

In keeping with the policy established by the FMA House of Delegates approximately $1,111,000 is budgeted for public relations and legislative activities. (The FMA Bylaws provides that $50 of each regular, active members' dues be applied to these two activities.) The 1987 FMA budget includes increased funding for public relations activities in cooperation with component county medical societies including increased speakers training programming, and an increase in the Association's legislative and medical economics activities.

FMA Reserves Trust Fund: The House of Delegates in 1980 authorized the Board of Governors to establish a special trust fund for the current and future reserves of the Association, the initial funding coming from the approximately $600,000 profit from the sale of the headquarters building in Jacksonville. The Trustees of this fund are the three (3) immediate past living presidents of the Association, excluding the Immediate Past President who is an officer. The principal and interest of these funds accrue in this trust account which shall be established in the name of the Association in an escrow trust. The trustees may release the funds upon request of the Board of Governors which indicates that an emergency exists which cannot be financed through regular income or assets of the Association. In the event the Trustees do not agree to release the funds, the Board of Governors may direct their release upon ¾ vote of the active members of the Board of Governors.

The net proceeds from the sale of the FMA property at 801 Riverside Avenue and the purchase of 760 Riverside Avenue left a net of $137,000 and, as directed by the Board, was placed in the reserve fund.

Payments on the mortgage are made annually in the amount of $166,257. The principal is applied to the trust fund and the interest to the FMA general revenue account. The interest earned through December 31, 1986, in the fund was $182,873 and the total balance in the trust fund as of December 31, 1986, was $825,255.

1984 FMA Assessment: The House of Delegates at a special called meeting on January 28, 1984, unanimously approved a mandatory assessment of $300.00 for all regular active dues paying members of the FMA to be utilized for implementing the FMA professional liability program. The assessment was billed on March 12, 1984, to 11,673 active members for whom the assessment was mandatory and to 2,866 members in other classifications, who were invited to pay the assessment on a voluntary basis. As of December 31, 1986, 10,719 active members have paid the assessment for a total of $3,215,700. A total of 752 voluntary payments were received for a total of $221,835.

In compliance with actions of the House of Delegates, these funds have been utilized solely for the FMA professional liability program.

Total expenditures from the assessment as of the date of this report were $3,564,489.78. The balance in the assessment account is $2,193.13.

In compliance with the directive of the House, 270 members were dropped from the FMA membership rolls effective January 1, 1986, for nonpayment of the assessment. Since that time $65,100 has been collected from 217 previously unpaid members.

Cuban Medical Association in Exile: The Board expressed its enthusiastic support for the FMA to continue co-sponsorship of the International Cuban Medical Association Congress for 1987 sponsored by the Cuban Medical Association in Exile to be held at the Sheraton Bal Harbour Hotel, Miami Beach, June 28-July 4, 1987.

AMA Elective Office: The Board determined that the Florida Medical Association not nominate candidates for elective office to the AMA during 1987, and requested the FMA Delegation to the AMA to develop procedures to be followed for selecting nominations for all AMA elective offices.

National Invitational Conference of Prescription Drug Abuse: The Board authorized the FMA to cosponsor a National Invitational Conference of Prescription Drug Abuse to be held in Florida during 1987.

Leadership Skills Seminar for Women Physicians: The Board approved a one-day, third annual Enhancement of Leadership Skills Seminar for women physicians to be held in conjunction with the 1987 FMA Leadership Conference.

Florida Physicians Insurance Company Stock Purchase: The Board authorized the FMA to enter into the appropriate agreements with the Florida Physicians Insurance Company (FPIC), which is the professional liability insurance company sponsored by the FMA, to purchase Class A common stock

in order to fulfill a previously authorized commitment by the FMA Board of Governors adopted in October of 1984. At its meeting in October of 1984, the Board committed to the purchase of common stock in FPIC at the request of the Florida Department of Insurance to help ensure the successful rehabilitation of the company. The stock purchase will be made over an approximate three-year period and will be added to the surplus of the Company.

The Board of Governors also authorized the FMA to enter into appropriate agreement with FPIC for the FMA to purchase Class B common stock that will give the FMA an approximate 45 percent ownership in the Florida Physicians Insurance Company.

FMA Young Physicians Section: The Board approved and referred to the Bylaws Committee the proposal to create a Young Physicians Section patterned after the FMA Resident and Medical Student Section, and adopted the AMA definition of "Young Physicians" which is any physician up to age 40 or in practice five years or less. The Board authorized the immediate creation of a steering committee to work on bylaws and other organizational details so the proposed section can become operational without undue delay after House action.

FLAMPAC Bylaws Amendments: The Board approved amendments to the FLAMPAC Bylaws which provides for:

- the election of officers by secret ballot; no person shall be eligible to serve as an officer unless that person has served on the Board of Directors of FLAMPAC for at least two years; and that no person shall be eligible to serve more than two consecutive terms in the same office;
- the automatic assumption of the office of President by the Vice President in case of the President's death or resignation; eliminates outdated language relative to District Representatives for National and State Elections;
- no member of the Board to serve as a Board member for more than eight years; grandfathers in those persons who will have served eight years or more at the effecive date of the amendments to allow an additional two years of service on the Board;
- the designation by the FMA President of one of the two FMA Board members serving on the FLAMPAC Board to be a member of the FLAMPAC Executive Committee;
- the designation of two members of the FMA Council on Legislation as members of the FLAMPAC Board;
- the FLAMPAC Executive Committee to include one of the two FMA Board members who serve on the FLAMPAC Board; removes requirement that Executive Committee serve as Candidate Selection Committee;
- at least three meetings of the Board;
- the President to call for meetings of Executive Committee and eliminate number of times required to meet each year.

Judicial Council

Postoperative Care by Optometrists: The Board adopted a proposed rule to be submitted to the Board of Medicine embodying the principles of Rule 8 of the Code of Ethics of the American Academy of Ophthalmology.

Use of Fictitious Names by Professional Associations: The Board authorized the FMA to take a position of no opposition to a proposed amendment to Section 621.12, F.S., to allow the use of fictitious names in the name of a professional association.

Interpretation of FMA Bylaws for Non-Licensed Physicians: The Board agreed to review the issue of whether county medical societies must accept non-licensed physicians into membership and that until such time as the bylaws are changed the Board affirms that county medical societies may have membership requirements more stringent than those of the Florida Medical Association and, therefore, are not required to accept non-licensed physicians into membership.

Committee on Membership Development

Membership Development: The Board approved sponsorship of a membership development workshop in the fall of 1987 and approved the AMA's being invited to cosponsor this program.

FMA Membership as a Condition of Licensure: The Board referred to the Council on Legislation the recommendation of the Committee that the Florida Medical Association **not** pursue legislation that

would require physicians to be members of the Association as a condition of licensure in Florida; and further, that the Florida Medical Association pursue any means that might be appropriate to broaden and enhance the authority and jurisdiction of the FMA and AMA judicial councils, as well as county medical society judicial councils, as a means of strengthening the medical disciplinary process.

County Medical Society Recognition of AMA Members: The Board approved the recommendation that county medical societies that publish pictorial directories of members be encouraged to identify American Medical Association members by printing the AMA symbol opposite their pictures; and further, that the Florida Medical Directory identify AMA members by a star or some other typographical device after or before their names.

Membership Communications: The Board approved the recommendation that the Florida Medical Association supply county medical society bulletins on a regular basis with articles about FMA accomplishments and efforts on behalf of the membership.

Survey of Non-Members: The Board approved a survey of Florida members of the American Medical Association who do not belong to the FMA to determine their reasons for not affiliating with organized medicine at the state level.

FMA Auxiliary Bylaws: The Board approved the recommendation to strongly encourage the Florida Medical Association Auxiliary to amend Section 1C, Article 1, of its bylaws to restrict membership in the FMA-A to spouses of physicians who are actually members of the FMA and not just eligible for membership.

Physicians Recovery Network

Proposed Change in Name of Impaired Physicians Committee: The Board approved the recomendation that the name of the Committee on Impaired Physicians be changed to "The Physician Recovery Network (PRN) Committee"; and that the name of the Impaired Physicians Program be changed to "Physician Recovery Network (PRN)."

Pilot Impaired Physician Epidemiologic Surveillance System: The Board approved the recommendation that the FMA participate in the Pilot Impaired Physician Epidemiologic Surveillance Sytem (PIPESS) of the American Medical Association Impaired Physicians Advisory Committee and the Caduceus Foundation of Smyrna, Georgia.

Confidentiality of Records: The Board authorized a review of the problem of confidentiality of records that are public information in the State Attorney's Office.

Professional Liability

As reflected in the preamble to this report, professional liability remains the most critical and pervasive problem facing the great majority of physicians and continues to be the Association's top priority. Since 1975, the FMA has continuously devoted a substantial amount of its staff and financial resources to this issue. During the past 12 years, the FMA has been successful in bringing about the enactment of numerous tort reform measures only to see them declared unconstitutional or not effectively implemented. Due to the failure to obtain effective and lasting relief from this problem through statutory changes, the FMA has looked beyond the legislative process to the constitutional amendment initiative process and to alternative mechanisms for resolving liability disputes outside the tort system as potential solutions to the problem.

The FMA House of Delegates, at its meeting in 1985, considered Resolution 85-12, Limitations to Medical Malpractice Liability, Dade County Medical Association, and Resolution 85-16, Workers' Compensation Approach to Medical Liability Insurance, Lee County Medical Society.

> RESOLVED, That medical liability on a no-fault and "workers' compensation" basis, with predetermined limits of liability, be endorsed as a viable alternative to the present tort system.

The House of Delegates combined these two resolutions into the above substitute resolution. This resolution was referred to the Board of Governors. The Board subsequently recommended to the House of Delegates at the 1986 FMA Interim Meeting that the FMA support the development and passage of

legislation which provides for resolving medical malpractice claims through a system which brings about resolutions for each claim outside the current civil litigation process. The Board took the following additional actions regarding PLI legislation for consideration during the 1986 legislative session:

- Support placing a cap on general damages (noneconomic);
- Support the elimination of the Doctrine of Joint and Several Liability;
- Continue to oppose the requirement of professional liability insurance for physicians as a condition of licensure;
- Evaluate the feasibility of a constitutional amendment campaign for 1988 as a means of resolving the professional liability crisis.

During the 1986 session of the Florida Legislature, the FMA, in cooperation with the Florida Coalition for Liability Reform, played a key role in gaining enactment of a significant Tort and Insurance Reform package, which was at that time the most comprehensive in the nation. It was anticipated that this landmark package would bring stability to Florida's professional and commercial liability crisis. Shortly after enactment of the law, the insurance industry and the Florida Academy of Trial Lawyers and other consumer groups filed suit seeking to have declared unconstitutional several key elements of the law including the $450,000 cap on noneconomic damages.

The Board of Governors, at its meeting in October 1986, directed that the FMA continue to pursue additional measures through the Florida Legislature or alternative approaches, if necessary, to contain and resolve Florida's professional liability crisis.

The Board further directed that the FMA continue to actively work with the Academic Task Force in preparing legislation for and/or a constitutional initiative for 1988; and further, that should the courts declare the tort reform provisions of the Tort Reform and Insurance Act of 1986 unconstitutional, that the FMA sponsor appropriate legislation in 1987 to reestablish those provisions with necessary modifications that will include the previously proposed $250,000 cap on noneconomic damages.

Your Chairman appeared before the Academic Task Force, at its meeting on November 25, and called on the Task Force to act quickly in addressing solutions to the continually escalating crisis. Citing the rate filings of the state medical malpractice insurance companies for rate increases averaging 35 percent to be effective January 1, 1987, I urged the Task Force to act quickly to address medical professional liability because its critical nature not only affected physicians but seriously impacted on the cost and availability of health care. I requested that the Task Force consider additional steps that might be taken by the 1987 Legislature rather than waiting until 1988, which is the time set for the Task Force to report to the Legislature.

The Task Force was also urged to begin an immediate evaluation of proposals that would remove the resolution of medical liability disputes from the tort system including the establishment of a contract mechanism for the resolution of disputes (MICA), and the establishment of a mechanism for offering economic damages as a means of addressing liability disputes (offer of economic damages). I also urged that the Financial Responsibility law be repealed or deferred and pointed out the unrest and uncertainty caused by the law and its adverse impact on the availability of medical services in the state.

The Board of Governors, at its meeting on January 31, 1987, discussed in depth the continually escalating professional liability crisis in Florida. Your Chairman outlined the FMA's activities over the past several months including meetings with the Florida legislative leadership, members of the Governor's senior staff, officials in Washington, appearances before the Academic Task Force and discussions with numerous county medical societies and others. The Board also reviewed the report and recommendations of the Council on Legislation relative to the FMA continuing professional liability activities.

The Board determined that it would hold an emergency special meeting for the express purpose of considering short and long-term solutions to the professional liability crisis on February 26.

The Board also directed:

1. That the FMA, through the continuing efforts of your Chairman and staff, work aggressively with the Task Force and, at the meeting of the Task Force on February 3, that recommendations be submitted for alternative proposals that would remove medical negligence disputes from the tort system.

2. That the FMA work aggressively with the recently appointed Governor's Task Force established

to address the trauma emergency room crisis in South Florida and support legislative solutions to the 1987 Legislature to resolve this crisis.

3. That during the 1987 legislative session, the FMA seek repeal or deferral of the financial responsibility provisions of the 1986 Tort Reform Law until such time as substantive long-term resolutions to the professional liability problem can be achieved.

4. That the FMA explore all other available solutions — public relations activities, coalitions and a special session of the Legislature — to resolve the professional liability crisis at the earliest possible date including short and long-term solutions.

5. That this policy be communicated to all members of the FMA through a special edition of the "President's Memo," other appropriate FMA communications and an appropriate media event emphasizing the emergency nature of the crisis and the need for an immediate solution.

The FMA Board of Governors subsequently held an emergency meeting to discuss the liability crisis on February 26, 1987, in Jacksonville. Representatives of component county medical societies were invited to attend. Dr. James Todd, Deputy Executive Vice President of the AMA, and Mr. Kirk Johnson, AMA General Counsel, also attended. At that meeting, your Chairman submitted a report and recommendations to the Board for incremental objectives that would, over a period of time (1987-88), achieve the ultimate goal of removing liability disputes from the tort system.

The Board took the following actions:

Limitation of Liability — Physicians in ER, Trauma Center — The Board directed that the FMA seek passage of legislation during the 1987 legislative session that will limit the liability of physicians who render emergency care and medical services in trauma centers, emergency rooms and those who admit patients to the hospital through emergency rooms; and further, that the Florida Medical Association work aggressively with the recently appointed Governor's Task Force established to address the trauma/emergency room crisis and support legislative solutions in the 1987 Legislature to resolve this crisis.

Limitation of Liability — Physicians Who Contract With the State — That the Florida Medical Association seek passage of legislation during the 1987 legislative session that will limit liability for physicians that provide services to patients of the state pursuant to a contractual relationship with an appropriate state department or agency.

Removal of Liability from Tort System — That the Florida Medical Association continue its efforts to develop legislation to be introduced at the earliest possible date that will establish a cost-effective system for resolving medical malpractice disputes.

Seek Repeal of Financial Responsibility Law — That the Florida Medical Association, during the 1987 legislative session, seek repeal of the financial responsibility law.

Academic Task Force — That the Florida Medical Association, through the continuing efforts of the President and staff, continue to aggressively work with the Academic Task Force on a continuing basis; and further, that a key contact physician be appointed for each member of the Academic Task Force.

Long-Term Activities — Public Relations Efforts, Constitutional Initiative — That the Florida Medical Association explore all other available solutions, including a constitutional petition revision in 1988, public relations activities and coalition activities in an effort to resolve the medical malpractice crisis at the earliest possible date, including short-term relief and long-term resolutions.

1986 Tort Reform and Insurance Act — The Board directed that in the event a portion or all of the Tort Insurance Reform Act of 1986 is declared unconstitutional, that the FMA introduce legislation during the 1987 session to reenact those portions of the bill deemed beneficial; and further, that the Indiana law be used as a guideline and that the elimination of noneconomic damages be an objective of any such legislation.

Constitutional Amendment — That the FMA reaffirm the FMA's long-range goal to place a constitutional initiative on the ballot in 1988 that would remove the liability issue from the tort system; and further, that the preparations for this initiative begin immediately following

the 1987 session of the Legislature pursuant to approval by the Executive Committee.

Public Education Program — That a comprehensive public education program in support of the Association's professional liability activities be carried out within the financial constraints of the Association and that support for this program be requested from FMA component county medical societies, specialty groups, the AMA and other affiliated or interested groups.

Protecting Physician Retirement Funds — That legal counsel research possible legislation in respect to protecting physician retirement funds from being attached in malpractice suits.

Dade County — That the FMA investigate the current statute of limitations law to determine if legislation is necessary to correct any determined deficiencies in the law.

The severity of the crisis heightened further when, on April 24, 1987, the Florida State Supreme Court declared the $450,000 cap on noneconomic damages unconstitutional. The constitutionality of the law had been upheld by the lower court. This was followed by announcements from the state's two largest medical malpractice carriers, St. Paul Insurance Company and CIGNA Insurance Company, that they would discontinue writing medical malpractice coverage for physicians in Florida effective July 1, 1987.

The FMA immediately took steps to ensure that adequate professional liability insurance protection remain available to Florida physcians. The Florida Physicians Insurance Company (FPIC) and the Florida Physicians Protective Trust Fund (PPTF), two of the remaining primary insurers, were requested to expand their capacity to provide coverage to those doctors who may be in jeopardy of losing their coverage after July 1. Continuing discussions were also held with Insurance Commissioner Bill Gunter seeking his support for maintaining a viable private market. Numerous conversations were held with representatives of St. Paul to encourage that they remain in the Florida market.

In the midst of the intense debate on the PLI issue during the 1987 session, the Board of Governors met jointly in Tallahassee on Wednesday, May 13, with officers, executive directors and other representatives of county medical societies, FMA recognized specialty groups and FMA Auxiliary leaders to discuss the Association's continuing activities to resolve the worsening crisis that was directly affecting access to health care.

The Board received a report and recommendations from the FMA Council of County Medical Society Officers that met earlier to receive input from officers representing 22 component county medical societies. Dr. Bruce Weissman, Chairman of the Council, presented the recommendations to the Board as unanimously adopted by the Council. Based on the recommendations of the Council and the input received from other county society and specialty group representatives attending the meeting, the Board took the following actions:

1. The Board reaffirmed its endorsement of the "Barron Plan," now known as the Medical Incident Compensation Act (MICA), as a potentially viable alternative mechanism to the current tort system for resolving liability disputes and called on the Legislature to enact the plan during the current legislative session. If unable to grant this ugrent request before the session ended, a special session should be held for this purpose. MICA was orginated by the Senior member of the Legislature, State Senator Dempsey Barron, D-Panama City. The plan, which has similarities to the State's Workers' Compensation Act, maintains provable negligence as the threshold for recovery of damages. It is not a no-fault program.

2. The Board reaffirmed its plans adopted in late February to continue to develop a constitutional amendment petition program to place a cap on noneconomic damages in the amount of $100,000.

3. The Board approved an FMA policy statement regarding the availability of insurance for physicians:

> The FMA is sympathetic to the problem being faced by those Florida physicians whose insurance coverage may lapse on July 1 due to the anticipated withdrawal from the insurance market by at least two major medical malpractice insurance companies in Florida. The FMA will continue working aggressively to assure the availability of insurance for these physicians that will provide adequate coverage at the most reasonable cost. Until such time as such insurance can be made available, the FMA recommends that physicians use every caution to refrain from practicing medicine in any manner which puts them in violation of current Florida statutes. The FMA is opposed to any plan that calls for a mandatory state operated insurance

pool or which calls for a subsidy of insurance premiums.

4. The Board referred to FLAMPAC for study and action the recommendation that physicians and local medical PACs become actively involved in the election and/or retention of judges. Circuit and county court judges are elected by the people. On the appellate and supreme court level, judges are appointed. But every six years, their names must be placed on the ballot for retention or rejection by the voters of Florida.

5. A proposed resolution was referred to the FMA Council on Legislation to evaluate the feasibility of legislation that would prohibit St. Paul and other insurance carriers from writing other casualty insurance without offering medical malpractice coverage at a balanced rate based on profits from other lines.

6. The Board reaffirmed the FMA's strong opposition to any legislative proposals similar to the Cleveland Clinic plan to locate in Broward County that would allow physicians to become licensed in Florida without having to follow the same prescribed procedures and examinations as other physicians who practice in the state as required by Florida law.

7. The Board authorized an investigation of the feasiblity of a class action suit against the CIGNA Insurance Company and St. Paul Fire & Casualty Company regarding the actual or potential withdrawal of insurance coverage for physicians in Florida.

8. The Board approved the recommendation that the FMA urge the St. Paul Insurance Company to continue to provide professional liability insurance coverage for physicians in Florida at affordable rates.

Following the May 13 meeting, members of the Board of Governors, along with Dr. Peter Tomasello, President of the Broward County Medical Association, representing the Council of County Medical Society Officers, met separately with House Speaker Jon Mills, D-Gainesville, and Senate President John Vogt, D-Cocoa Beach. The Speaker and President offered cooperation in granting members of the Legislature an opportunity to analyze and consider resolutions to the liablity crisis including the Barron proposal. Attending the session with Senator Vogt were Senators Dempsey Barron, D-Panama; Tony Jennings, R-Orlando; and Mattox Hair, D-Jacksonville. Senator Barron indicated to the Board that he would give his full commitment to the enactment of his proposal during the 1988 session. It was not possible to gain substantial support for the passage of MICA during the 1987 session.

Prior to the 1987 session, the House and Senate legislative leadership told the FMA that no tort reform measure would be considered until the Academic Task Force, created by the 1986 Legislature, completes its review of the entire liability problem and submits its report and recommendations to the Legislature prior to the 1988 session. Appeals were renewed to the Governor, the legislative leadership and the Academic Task Force to act expediently to resolve the problem during the 1987 session. Unfortunately, this was not to be the case, and the Florida Legislature adjourned without having enacted any tort reform measure.

At the urging of FMA and others, Governor Bob Martinez has taken a leadership role in addressing the crisis. The Governor has indicated that he will call a special session of the Legislature this fall, possibly in September, to deal with the issue. As of the date of this report, the Governor has not set a date for the session.

In preparation for a special session and other FMA action to resolve the PLI problem, your FMA Board of Governors, at its meeting on June 13, approved the following actions:

1. That an Ad Hoc Committee on Professional Liability be appointed to be charged with the primary responsibility for the coordination and implementation of the FMA's PLI activities with approval of the Board of Governors in support of its state objectives for evalutation of the Medical Incident Compensation Act (MICA) by the Florida Legislature as a resolution to the liability crisis, and the placing of a constitutional amendment on the 1988 general election ballot that would place a cap of $100,000 on the amount of noneconomic damages that may be awarded in any civil liability dispute.

2. That a support group of outside consultants as determined appropriate by the Committee be designated to assist the Committee in its activities.

3. That the FMA provide financial resources from surplus funds of the Association and other sources that may be identified to carry out the activities of the Committee related to the special session.

4. That the FMA conduct an immediate public opinion poll to ascertain current public attitudes in respect to the professional liability problem that has caused a serious health care crisis.

5. That the FMA request the Florida Medical Association Auxiliary to immediately initiate a petition drive for a 1988 referendum to amend the Florida Constitution.

(The FMA Auxiliary accepted the challenge to organize and implement the initial phase of a signature petition campaign to obtain the signatures required to place a constitutional amendment on the election ballot. The Auxiliary's goal is to obtain 100,000 signatures of qualified Florida voters by September 1.)

6. That the FMA organize a physician/layman march to the district office of each member of the Florida Legislature at least one week prior to the special session.

7. That the FMA work with the leadership of the House and Senate and the Governor's Office to solidify support for the FMA position during any special session.

8. *That the FMA immediately ask for voluntary contributions from all FMA members as well as licensed physicians in Florida and other appropriate professional groups for a public information campaign to establish a basis of support for the FMA position on professional liability; and further, that county medical societies be requested to assist in soliciting and collecting these funds.

*The FMA has no remaining funds from the 1984 PLI assessment and the financial support of all FMA members is absolutely essential if we are to succeed in carrying out the professional liability objectives which I have outlined.

A minimun contribution of $500 per physician was needed to continue our efforts that will include a comprehensive public education campaign for gaining support for the FMA's legislative program in the special session and the constitutional amendment signature campaign.

The professional liability crisis has, for many physicians, become a crisis in caring. Because of the high cost of liability insurance and the increasing litigiousness of the medical care delivery environment, physicians have been forced to restrict or discontinue critical and often life saving health care services. Some have been forced to quit practicing medicine altogether. All of us have great sympathy for the plight of the physicians in South Florida who are being forced to endure the worse effects of this terrible problem. The frequency and severity of claims as well as the level of liability insurance premiums are twice that of the rest of the state. The FMA has worked diligently to resolve the crisis for all the physicians of Florida in every forum and has pointed to the perilous severity of the conditions in which physicians in South Florida find themselves. FMA has endeavored to keep its component county society leadership and the entire membership fully informed regarding the FMA's extensive and broad-based PLI activities.

The Legislature will be presented with many proposals for resolving the crisis including the impending report and recommendations from the Academic Task Force. A supplemental report on the status of FMA's PLI activities and events relating to the special session of the Legislature and the constitutional amendment campaign will be included in the Delegates Packet.

REPORT D
of the Board of Governors

James B. Perry, M.D., Chairman
(Reference Committee No. IV , page 1068)

HOUSE ACTION: ADOPTED

The Annual Reports on the major activities of the Council on Legislation and FLAMPAC are included in this section of the Delegates Handbook. The Board has carefully reviewed the activities of the Council and FLAMPAC during the past Association year. The following is a summary of the actions taken on the Council's recommendations regarding important legislative issues effecting to be addressed during the 1987 Session of the Florida Legislature.

COUNCIL ON LEGISLATION

Professional Liability: The Board considered numerous recommendations from the Council regarding the continuing professional liability crisis. A comprehensive report on the FMA Board of Governors actions and the Association's PLI activities is included in Report C of the Board of Governors, Reference Committee III.

Indigent Health Care: The Board voted to place high priority on the funding for an enactment of a comprehensive indigent health care program in the 1987 Legislative Session to include sovereign immunity for providers participating in the program.

Trauma Centers: The Board agreed that a high priority item in FMA's 1987 legislative program be the enactment of a law providing for regional designation of trauma centers.

Medical Practice Act: The Board reaffirmed the position of the FMA to oppose further exception to licensure of physicians in the State of Florida such as those contained in the "Mayo Clinic" exceptions to the Medical Practice Act adopted in 1985.

Not-For-Profit Corporation Liability: The Board supported legislation to provide exemptions from liability for not-for-profit professional associations and their directors and officers.

Sales Tax on Health Care Professional Services: In compliance with Resolution 86A-16, adopted by the House of Delegates in 1986, the Board reaffirmed the FMA's opposition to the imposition of a sales tax on health care professional services and supported legislation to reenact the sales tax exemption on health care professional services that was repealed along with the exemption on all services during the 1986 legislative session.

Mandatory Assignment as a Condition for Licensure: The Board ratified support for Resolution 86A-24, Licensure and Assignment, that would direct the FMA to oppose mandated acceptance of a third-party payor assignment as a condition for licensure.

Resolution 86A-24 adopted by the House of Delegates in 1986 resolved.

Expansion of "Good Samaritan" Law: The Board supported legislation strengthening the Florida "Good Samaritan" Law to provide better protection for physicians donating their time and conducting sports participation physical examinations and physicians donating their time on or off the field for sports programs at all levels including municipalities.

Improved Trauma Center Verification: The Board approved support for legislation during the 1987 session establishing improved verification of trauma centers and a proposal containing protection from liability for participating providers in the system.

Preferential Licensure Treatment for Physicians: The Board continued opposition to any changes in Florida Law including the Medical Practice Act and/or Section 617.01 dealing with incorporation of certain medical service corporations that would provide preferential licensure treatment for physicians desiring to practice medicine in the State of Florida.

Reorganization of the Department of Health and Rehabilitative Services: The Board supported efforts to reorganize the Department of Health and Rehabilitative Services to provide for greater identity and authority for the health components of the Department with the eventual goal of a separate Department of Health.

Hospital Staff Privileges for Non-Physicians: The Board continued to oppose mandated hospital staff privileges for non-physicians.

Funding for Florida Cancer Control and Research Advisory Board: The Board supported funding for the Florida Cancer Control and Research Advisory Board (CCRAB) that would provide for: (1) completion of the Florida Cancer Plan; (2) an increase in funding for the Florida Cancer Data System (FCDS); and (3) early cancer detection for the economically disadvantaged.

Workers' Compensation Fee Schedules: The Board supported enabling legislation in 1986 to authorize individual physicians to negotiate with insurance carriers on respective Workers' Compensation Fee Schedules.

Interest on Judgments: The Board approved in principle support for a change in current law to modify a constant rate of interest on judgments to be tied to an index based upon a specific variable formula.

DRGS for Physicians: The Board supported the American Medical Association's opposition to prospective payment (DRGS) for hospital-based physicians.

FMA 1987 Legislative Program: The Board received a report from the Council on the actions taken by the 1987 session of the Florida Legislature regarding approximately 360 bills of interest to medicine. The annual report of the Council on Legislation included in this section of the Delegates Handbook contains a detailed report on those issues supported or opposed by the FMA.

Despite the fact that the legislature failed to enact any tort reform measure, the Board commended the Council, the Committee on State Legislation, FMA Auxiliary and the many individual physicians and FMA staff for the outstanding legislative achievements on non-PLI issues during the 1987 session.

Legislative Appreciation Awards: The Board approved an appropriate recognition award for the following legislators to be presented at the 1987 FMA Annual Meeting in recognition of their support of the FMA's legislative objectives during the 1987 session.

Rep. Alzo Reddick
Rep. David Thomas
Rep. Betty Metcalf
Rep. Susan Guber
Rep. Bolley L. "Bo" Johnson
Rep. Tim Deratany
Senator Mattox Hair
Senator William "Doc" Myers

State Medical Licensure Requirement: The Board reiterated FMA policy that licensure to practice medicine in the State of Florida be based on training and competence and not on socio-economic principles.

FLAMPAC

Activities: The Board received reports regarding the activities of FLAMPAC which included information on the 1986 elections. In the First Primary, FLAMPAC was on the winning side of 29 candidates with only six endorsed candidates losing. In the runoff election, FLAMPAC supported 12 candidates including two members of the medical community. A major achievement of FLAMPAC has been the increased personal involvement of physicians and auxilians in campaigns throughout the state. In the 1986 elections, there were seven physicians and five auxilians who offered themselves to election.

Membership: Membership in FLAMPAC continued to be strong with a total membership of 4,646 as of September 15, 1986. However, this is 1,205 short of the 1986 goal of 5,851. Of particular concern is the large number of physicians who did not rejoin.

Board of Directors: The Board approved the appointment of the FLAMPAC Board of Directors as follows:

19 From Congressional Districts

1st	William W. Thompson, M.D.
2nd	Terence P. McCoy, M.D.
3rd	Mrs. James H. Corwin
4th	James G. White, M.D.
5th	Richard J. Bagby, M.D.
6th	Frank R. Wilkerson Jr., M.D.
7th	Frank C. Coleman, M.D.
8th	James L. West, M.D.
9th	Donald G. Nikolaus, M.D.
10th	John W. Glotfelty, M.D.
11th	Brian P. Gibbons, M.D.
12th	Donald Ames, M.D.
13th	Kenneth C. Keihl, M.D.

14th Dick L. Van Eldik, M.D.
15th T. W. Hahn, M.D.
16th Stanley I. Margulies, M.D.
17th James W. Bridges, M.D.
18th William I. Roth, M.D.
19th Warren Lindau, M.D.

Three From FMA Auxiliary
Mrs. B. David Epstein
Mrs. Arthur L. Eberly
Mrs. Don E. Sokolik

Two From FMA Board of Governors
Luis M. Perez, M.D.
Yank D. Coble Jr., M.D.

Two From Committee on State Legislation
Thomas M. Daniel, M.D.
Louis C. Murray, M.D.

Six From State At-Large
H. Quillian Jones Jr., M.D.
R. Benjamin Moore, M.D.
Carlos G. Llanes, M.D.
Juan Wester, M.D.
Alvin E. Smith, M.D.
Richard S. Hodes, M.D.

Auxiliary President-Elect (Ex-Officio)
Mrs. Rex Orr

REPORT E
of the Board of Governors

James B. Perry, M.D., Chairman
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED

BOARD ACTIONS OF MAJOR IMPORTANCE

FMA COUNCILS AND COMMITTEES

COUNCIL ON MEDICAL ECONOMICS

The Annual Report of the Council on Medical Economics is included in this section of the Delegates' Handbook. The Council's activities during the past Association year were carefully reviewed by the Board and the following report and/or recommendations are submitted to the House regarding each of the items addressed by the Council.

Workers' Compensation Legislation: The Board approved FMA seeking to develop legislation and related regulations during the 1987 session that would permit alternative contractual arrangements between payors and physicians providing services within the Workers' Compensation Program. Financial support would be sought from affected specialty groups in order to assist in the cost of this program.

Workers' Compensation Consultant: The Board agreed to continue to retain John H. Lewis, Esq., as a consultant to assist in rewriting the current Workers' Compensation Laws subject to satisfactory negotiations.

Physician Advisors for the PRO: The Board encouraged the FMA membership to volunteer to become physician reviewers for the Professional Foundation for Health Care, Inc.

PRO Legislation: The Board directed the Florida Medical Association to seek, through appropriate avenues, revisions in the Health Care Financing Administration Regulations that require admission denials as a result of incorrect attestation signatures, incorrect dates and improper coding.

HMO Financial Disclosure: The Board directed FMA General Counsel to ask the Department of Insurance whether financial disclosure of HMOs', PPOs' and other types of prepaid plans' itemized expenses is allowable under current law. In the absence of such provisions under current law, the FMA would explore the feasibility of legislation requiring the reporting of itemized expenses for administrative, advertising and medical care services. The FMA will seek support in this endeavor from such groups as the AARP and others as may be appropriate.

Commendation for Jacques R. Caldwell, M.D.: The Board commended Jacques R. Caldwell, M.D., for his informative, well written articles on medical economic issues that have been published in the *Journal of the Florida Medical Association, Inc.,* during the past year.

Funding of Indigent Care: The Board continued to support a broad-based funding approach for the financing of indigent health care, as well as a primary care and preventive medicine delivery system that emphasizes the coordination of public and private sector services to indigents.

County Public Health Units: The Board approved and referred to the Council on Legislation the recommendation that the FMA seek the enactment of legislation providing for county public health units to serve as brokers of indigent care to the private sector with provisions for appropriate alternative brokers.

Sovereign Immunity: The Board approved and referred to the Council on Legislation the recommendation that the FMA seek the enactment of legislation that would include the extension of the State's limited sovereign immunity to cover physicians providing care to indigents on contract with county public health units and all physicians providing care to indigents through State and/or Federally funded programs and insurance mechanisms.

Physician Reimbursement: The Board approved and referred to the Council on Legislation a recommendation that the FMA seek the enactment of legislation that will provide for increases in provider reimbursement levels for physicians, dentists, EPSDT (Early Periodic Screening, Diagnois and Treatment) and home health care services as recommended by the Department of Health and Rehabilitative Services.

Reorganization of the Department of HRS: The Board supported efforts to reorganize the Department of Health and Rehabilitative Services to provide for greater identity and authority for the health components of the Department with the eventual goal of a separate Department of Health.

Workers' Compensation Fee Schedules: The Board supported enabling legislation to authorize individual physicians to negotiate with insurance carriers on respective Workers' Compensation Fee Schedules.

DRGs for Physicians: The Board expressed support for the position of the American Medical Association opposing to prospective payment (DRGs) for hospital-based physicians.

Specialty Charge Survey: The Board authorized the FMA to provide assistance, if requested, to the Hospital Cost Containment Board's Office of Technical Assistance in respect to any of its activities authorized by law provided such assistance is approved by the Council on Medical Economics and reviewed by FMA General Counsel.

Public Health Code: The Board authorized the FMA to explore the feasibility of continuing to develop a Florida Public Health Code during the 1987 and 1988 Legislative Sessions and develop legislation to enact the codification of Florida's public health and health related laws.

Medicaid Increases: The Board approved the recommendation that the FMA approach the new Governor of the State of Florida to assure that Medicaid provider reimbursement increases are not deleted from the Governor's budget, pursuant to recommendations approved by the Board of Governors at its October, 1986, meeting.

AIDS Education: The Board authorized the FMA, in conjunction with county medical societies, to continue to assist the Florida Department of HRS in the mission of publicizing more information about AIDS to the public and to health care providers.

PRO Denial Letters: The Board directed the FMA to draft proposed letters for PRO quality denials to be submitted to the Professional Foundation for Health Care, Inc., and the Health Care Financing Administration in an effort to help minimize any misconceptions about the quality of care provided by a physician.

Committee on PRO: The Board opposed amendments to the Professional Foundation for Health Care Bylaws that would alter the nomination procedure for membership on the PFHC Board from the current procedure to a requirement providing that nominees present a written petition which "Contains the signatures of 25 percent of the membership from each of the three regions of the State as designated in the corporation's contract with the Health Care Financing Administration."

Medicaid Drug Utilization Review: The Board directed the FMA, through county and state level review processes, to seek to become officially involved in the Medicaid Drug Utilization Review of physicians in the most appropriate role.

Commendation for William H. Dodd: The Board commended William H. Dodd for his contributions to the Florida Medical Association for the past twelve years by providing exceptional expertise in the development of the *Florida Relative Value Studies*.

PRO Complaints: The Board agreed to continue to review individual complaints received from the membership about problems they have encountered with the Professional Foundation for Health Care.

PRO Physician Reviewers: The Board agreed to continue to encourage physicians to participate as reviewers for the Professional Foundation for Health Care. All county medical society and specialty society recommendations will be coordinated and forwarded to the Professional Foundation for Health Care by the FMA.

PRO Sanctions: The Board supported the American Medical Association's request to the Health Care Financing Adminstration that the current sanction process be revised to allow for adequate due process for physicians being considered for sanction and that all appropriate appeals be exhausted before a sanction is imposed and made public.

Super PRO: The Board directed the FMA to provide documentation detailing the inappropriate activities of the Super PRO to the AMA for the purpose of requesting the Health Care Financing Administration for corrective action.

International Medical Centers: The Board directed the FMA to request that HCFA fund TV public service announcements informing enrollees about disenrollment procedures.

AARP: The Board directed the FMA, through the Council on Medical Economics and Council on Medical Services, to develop a mechanism for establishing liaison with the American Association of Retired Persons and other senior citizen organizations to address the issues of concern regarding accessibility, affordability and quality of health care and other issues of common interest.

COUNCIL ON HOSPITAL MEDICAL STAFFS

Model Staff Bylaws: The Board approved the development of model staff bylaws to be utilized by hospital medical staffs in Florida.

Physician Conflict of Interest: The Board adopted as policy that all nominees (physicians) for election to Hospital Medical Executive Committees must disclose to the Medical Executive Committee and the Medical Staff all personal, professional or financial relationships which could result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

Risk Management Seminars: The Board reaffirmed and recommended that the Council on Hospital Medical Staffs continue to provide technical assistance to the risk management seminars conducted by FMA staff for the FMA membership. Over the past year, the Florida Medical Association has conducted over 25 seminars for FMA members and will continue to do so. Twelve seminars are already

scheduled for the 1987/88 Association year.

AMA/HMSS Breakfast Caucus: The Board agreed to sponsor the Florida State Breakfast Caucuses at the AMA Annual and Interim Meetings of the Hospital Medical Staffs on an ongoing basis. Breakfast caucuses for the Florida Delegation to the Hospital Medical Staffs Section have been very well attended over the past three years. The Council recognized the importance of this network through the AMA and emphasized the need for the FMA to continue to encourage hospital medical staffs to attend the AMA Interim and Annual Hospital Medical Staffs meeting.

Risk Management: The Board agreed that the Council should continue to develop mechanisms to act as a catalyst to encourage specialty societies to develop malpractice prevention standards and develop working relationships with hospital risk managers through the Florida Hospital Association. This will enable specialty societies to identify key problem areas where the physician is at risk and assist the hospital in loss prevention.

Florida Association of Medical Staff Services: The Council on Hospital Medical Staffs, with the approval of the Board, established liaison with the Florida Association of Medical Staffs as a mechanism to communicate with grass roots physicians on various hospital medical staffs.

Professional Liability Crisis: The Board approved a statewide emergency meeting of the Council on Hosptial Medical Staffs with representatives from each hospital medical staff to be held in August prior to the special Legislative Session in September for the purpose of obtaining information from grass root levels on problems pertaining to hospital emergency rooms. In addition, this meeting will be utilized to discuss the FMA's current and future plans relative to the malpractice crisis.

REPORT F
of the Board of Governors
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

PROFESSIONAL LIABILITY

The following is a supplement to the report on the status of the Association's professional liability activities included in Report C of the Board of Governors in the Delegates Handbook.

The FMA Board of Governors met jointly with officers and executives of 20 component county medical societies and 21 specialty groups on August 15 in Tampa for a briefing on the FMA's ongoing efforts to resolve the state's worsening liability crisis including a two-pronged approach:

- A special session of the Florida Legislature to address the medical liability crisis.
- A constitutional amendment campaign to limit noneconomic damages in all liability disputes.

The Florida Medical Association has, in accordance with the policy established by the FMA House of Delegates and with the support of the county medical societies, endorsed the principles embodied in the Medical Incident Compensation Act (MICA) proposal as a viable alternative to the current tort system for resolving medical liability disputes (Appendix F-1). This proposal, which was formerly known as the Barron Plan, has been under review for several years. In 1985, an actuarial analysis of the proposal was conducted by St. Paul Insurance Company to measure its effectiveness in favorably impacting on liability insurance rates. The findings of that study were for the most part favorable, although the plan in its original form contained some provisions which raised concerns as to its impact. This dealt primarily with long term disability benefits. Since that time, the proposal has undergone several modifications and the FMA is currently working with a number of consultants in continuing to review the proposal to insure that its final construction will in fact result in a more substantive favorable impact on reducing liability rates. Also, the FMA retained the actuarial firms of Tillinghast, Nelson & Warren, Inc., and Milliman & Robertson, Inc., to conduct independent updated actuarial analyses of MICA. These studies have been completed and reflect that the MICA proposal would result in a positive savings in cost over the current tort system.

Some opponents, in attempting to foster confusion about the MICA, have continually referred to it as a no-fault plan that would break the bank. This is simply not true. The MICA proposal is not a **no fault** program. Provable negligence is maintained as the threshold for compensable damages. The most significant improvement over the tort system included in the proposal has to do with the elimination of risks in inequities, excesses and hardships that are so prevalent under the present system.

MICA offers a significant improvement to the current tort system for resolving medical malpractice claims. The plan establishes, through positive incentives, benefits to injured parties, health care providers and insurers by expediting early resolution of claims and maximizing payment of economic losses. The plan eliminates many risks, inequities, excesses and hardships that are inherent in the current tort system.

By utilizing a defined benefits schedule similar to the established Florida Workers' Compensation System, the MICA plan provides a party injured by negligence with assurance that their medical expenses and lost wages will be paid as incurred. By allowing the health care provider an opportunity to review the merits of a claim and provide the claimant with their economic losses in the event the claim is justifiable, the claim can be resolved without the need to resort to the unpredictable, lottery oriented tort system. The plan, by requiring the health care provider to pay attorneys' fees in addition to economic losses in the case of a successfully disputed claim by an injured party, creates a strong incentive for the defendant to fairly and quickly evaluate a potential claim.

The health care provider is responsible for ensuring that the claimant is paid pursuant to the benefits provided under the plan. The health care provider may insure or self-insure in order to provide such benefits. Self-insurance may be authorized by providing satisfactory proof to the Department of Insurance of the health care provider's financial stability to pay compensation.

The plan provides to a claimant injured by negligence all medically necessary treatment and care for such period as the nature of the incident or the process of recovery may require including medicines, medical supplies, medical equipment, prostheses and any other medically necessary equipment.

In addition, the plan provides for rehabilitative services and supplies as necessary.

The patient will be entitled to receive benefits of lost wages and permanent impairment computed under the provisions that are similar to Florida Workers' Compensation "Wage Loss" provisions.

There are no general damages. A patient who dies as a result of a compensable incident will receive compensation based upon statutorily determined percentages of the statewide average weekly wage to be paid to persons entitled to receive those benefits on the account of dependency. An additional death benefit under this provision for a minor or an adult would be provided up to $100,000.

A person who is injured through medical negligence will be much better off under the MICA plan than under the present tort system. If the right to damages can be established, that person will not have to roll the dice to see whether he or she is undercompensated or overlycompensated. The individual will not have to share his award with his attorney (attorneys' fees are in addition to the award) and the benefits will be paid forthwith. Moreover, the benefits are designed to fairly compensate the injured person for the adverse effects of the incident so long as those adverse effects persist. This plan brings predictability and stability into the pricing mechanism for medical malpractice insurance that are not possible under the present system.

Notwithstanding any substantive tort reform measure(s) enacted by the Legislature the immediate effect on reducing liability insurance premiums will be minimal and will improve during succeeding years.

The FMA feels that a short-term plan to relieve the extreme cost of professional liability insurance for physicians is an integral part of the long-term solution to the PLI crisis. The FMA Board of Governors has authorized an immediate investigation of subsidy plans to relieve some of the financial burden for physicians who are paying a large percentage of their gross income for professional liability protection. The premium subsidy concept would be implemented on a voluntary basis and would provide for distributions to be made for eligible physicians seeking financial relief on the basis of the amount of the physician's professional liability premium as a percentage of gross income derived from the delivery of medical services. Such a plan would be enacted for a specific short term period with an approprate sunset date and would include an appropriate financing mechanism from such sources as general revenue, a minimal premium tax on certain insurers or the Insurance Commissioner's regulatory trust fund.

The FMA recognizes that while the regulatory authority of the Department of Professional Regulation and the Board of Medicine are adequate for the licensure and regulation of physicians, including disciplinary functions, there may be appropriate ways to enhance these mechanisms that are rightfully intended to protect the public's health against any practitioner of medicine who falls below the accepted standards of education, training and qualifications for the privilege of the practice of medicine. The FMA Board of Governors has authorized review of appropriate mechanisms for enhancing the authority of the Department of Professional Regulation to review physician conduct in respect to medical malpractice actions and that recommendations regarding a proposal in this regard for possible consideration by the Florida Legislature be submitted to the Board of Governors for review and action at the earliest possible date.

Florida Governor Bob Martinez has indicated that he will call a special session of the Florida Legislature this fall to address the liability issue. However, at the time of this report no specific date for the session has been set. The Governor has recently indicated that the session would be called no later than November.

The Governor has appointed a 12-member legislative work group composed of representatives appointed from his office, the president of the Senate and speaker of the House. The work group has been charged with reviewing the numerous proposals that have been put forth and seek to develop a consensus for a solution to the problem.

Experience has shown that the legislative process cannot be totally relied upon for an effective and fair solution. Experience has also caused equal apprehension about the fate that may befall any legislation enacted in the hands of the Florida State Supreme Court. The FMA has therefore determined that an amendment to the Florida Constitution through the public referendum process is essential to ensure success of the FMA's PLI efforts.

The Constitutional Amendment Campaign that has been initiated by the FMA and the FMA Auxiliary is well underway. This initiative seeks to have placed on the ballot for vote by the citizens of Florida a proposed amendment to the Florida Constitution that places a cap of $100,000 on the amount that can be awarded for noneconomic damages in all liability disputes.

An amendment to Florida's Constitution was approved by the voters in November implementing a mechanism to have proposed constitutional amendment certified in advance by the Florida State Supreme Court as meeting the single subject and title requirements for proposed constitutional amendments. The preliminary goal of 35,000 signatures will meet the requirement for having the proposed amendment reviewed by the court. (Anyone seeking to have an amendment reviewed must first collect enough signatures to equal 10% of the number required to have an amendment placed on the ballot.) To successfully place a constitutional amendment on the ballot, it is necessary to obtain signatures of registered voters to equal 8% of the number in the last Presidential election. In the 1984 Presidential election, 4,286,000 Floridians voted. Therefore, 342,939 certified petitions are required to place an amendment on the ballot.

The FMA will also be working through the Florida Coalition for Liability Reform established in 1986 to establish the broadest possible base of support and involvement for the constitutional initiative effort, including all segments of the health care industry, private business and industry, and the general public.

The cost of successfully conducting the constitutional amendment campaign is extremely expensive. It is estimated that it will cost approximately $5 million to conduct a campaign that must include a broad-based public education program because of the complexity of the issue.

The support for capping noneconomic damages has been well documented and has been achieved in a number of states at various levels. In a study of the liability problem completed in 1986, the U.S. Justice Department concluded that a cap of $100,000 on noneconomic damages is fair and reasonable. Empirical analysis of post-1975 tort reform found that caps on awards have been one of the most effective means of holding down costs. A cap in effect for two years was estimated to reduce average claims severity by 19 percent (Danzon, 1984). In 1982, the accounting firm of Peat, Marwick and Mitchell completed a study analyzing the effects on premiums of placing limits on awards for noneconomic damages. This study concluded that capping noneconomic damages at the $250,000 level would result in an approximate savings of from 6 - 11 percent and that capping damages at the $100,000 level would result in savings of 17 - 25 percent.

Additional studies during that time period showed that states who moved to cap verdicts (damages) or allow periodic payments in lieu of lump sums had the net effect of lowering jury awards by approximately 30 percent and reducing the cost of court settlements by 25 percent. In a more recent study, the actuarial consulting firm of Milliman & Robertson, Inc., estimates that a cap on noneconomic damages of $100,000 would result in a savings of approximately 12 percent for $1 million policies and 16 percent for $2 million policies. The actuarial firm of Tillinghast, Nelson & Warren, Inc., estimates that a savings of between 15 and 20 percent of total costs could be realized as a result of the $100,000 cap on noneconomic damages. Recent public opinion polls reflect a steadily increasing level of public awareness about the liability problem as well as support for substantial actions to resolve it, including capping the total amount of awards paid in liability disputes. The FMA has commissioned an updated public opinion poll regarding this issue.

A signature petition form for the amendment has been provided to all members of the FMA with the request that they have the form duplicated for distribution to their office staff, patients, family and others, and request that they sign the form in support of this effort. The form should be returned to the FMA Headquarters Office, Post Office Box 2411, Jacksonville, Florida 32203.

The increasing level of public awareness and support for extraordinary action to resolve the professional liability crisis has been clearly demonstrated in recent public opinion polls. There is also growing support from the leadership and grassroots members of the Legislature. The opportunity for resolving this long debilitating problem has never been greater. But, an unrelenting resolve and a total unified effort is medicine's best hope.

REPORT G
of the Board of Governors

(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED AS AMENDED

COMMITTEE ON BYLAWS

The Board reviewed the report of the Bylaws Committee and makes the following recommendations for amendments to the FMA Bylaws concerning:

- Creation of a Young Physicians Section.
- Appointment of the Vice Speaker as an Advisory Member of the Board of Governors.
- FMA Provisional Members.
- Advisory Members Board of Governors.
- AMA Alternate Delegates.

Young Physicians Section: The Board approved and referred to the Bylaws Committee the proposal to create a Young Physicians Section patterned after the FMA Resident and Medical Student Sections, and adopted the AMA definition of "Young Physicians" which is any physician up to age 40 or in practice five years or less. The Board authorized the immediate creation of a steering committee to work on bylaws and other organizational details so the proposed section can become operational without undue delay after House action.

RECOMMENDATION NO. G-1
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING AMENDMENTS TO THE FMA BYLAWS TO PROVIDE FOR THE ESTABLISHMENT OF A YOUNG PHYSICIANS SECTION:

CHAPTER VIII
Councils and Sections

Section 4

C. There shall be a special Section for Young Physicians of the Florida Medical Association. The Young Physicians Section shall be entitled to one voting member of the FMA House of Delegates, provided such delegate shall be a member of the Young Physicians Section and the FMA.

1. The Young Physicians Section shall be organized pursuant to bylaws approved by the Board of Governors.

2. There shall be a business meeting of the Young Physicians Section members of the FMA annually. The business meeting shall be held in conjunction with the annual meeting of the FMA at a time and place to be designated by the Governing Council of the Section in consultation with the FMA Board of Governors.

3. The Young Physicians Section may adopt resolutions for submission and consideration to the House of Delegates of the FMA.

CHAPTER IV
House of Delegates

Section 1

The House of Delegates is the legislative and business body of the Association, and its members are the delegates officially elected by the component societies, specialty societies, Hospital Medical Staffs Council, Young Physicians Section, Medical Student Section, and Resident Section, in accordance with the provisions of these bylaws and Speaker and Vice Speaker of the House.

Section 6. Determination of Delegates

Each component society shall be entitled to select annually and to send to each meeting of the House of Delegates one delegate for every forty active members of the Association within that society, and one for any fraction over and above the last complete unit of forty, as shown on the Association's records on December 31 of the preceding calendar year, provided that each component society holding a charter from the Association shall be entitled to at least one delegate.

Each specialty society recognized by the FMA, the Council on Hospital Medical Staffs, the Young Physicians Section, the Medical Student Section and the Resident Section shall be entitled to select annually and send to each meeting of the House of Delegates one delegate who shall be entitled to one vote. No delegate may represent more than one organization entitled to representation in the House of Delegates.

The House of Delegates shall have the power to determine its own membership and may by three-fourths vote of those delegates present in official session refuse to seat any delegate or alternate delegate.

Section 12. Alternate Delegates

Each component shall elect alternate delegates corresponding in number to the delegates to which it is entitled, and shall designate to the Secretary of the Association the order in which they are to serve. Each specialty society entitled to have a delegate, the Council on Hospital Medical Staffs, the Young Physicians Section, the Medical Student Section, and the Resident Section shall be entitled to select one alternate delegate to serve with its delegates.

CHAPTER VII
Board of Governors

Section 1. Composition

The Board of Governors shall consist of the following members who have been elected by the House of Delegates: President, President-Elect, Vice President, Secretary, Treasurer, the two Im-

mediate Past Presidents, one representative from each Medical District, a Resident Physician, and a young physician who is a member of the Young Physicians Section. In addition to the above, the Board of Governors shall consist of the following members who shall be appointed by the President: a medical student of a term of two years, provided this position shall be rotated consecutively among the three Florida medical schools; an at-large member for a term of one year; and one of the delegates to the House of Delegates of the AMA for a term of one year.

CHAPTER V
Elections

A young physician, who is a member of the Young Physicians Section, shall be elected by the House of Delegates to serve as a member of the Board of Governors for a term of two years beginning in 1988 and thereafter every two years.

Vice Speaker -- The House of Delegates at its meeting in 1986 adopted Resolution 86A-1 which provided that the Vice Speaker be made an advisory member of the Board of Governors. The FMA bylaws provide that amendments to the bylaws must be initiated by the Board of Governors. The Board at its post convention meeting in September 1986 determined that the Vice Speaker would serve in the capacity of an advisory member of the Board as set forth in the resolution and to submit the appropriate amendment to the bylaws to the House of Delegates at the 1987 Annual Meeting.

RECOMMENDATION NO. G-2
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING AMENDMENT TO THE FMA BYLAWS, PROVIDING FOR THE FMA VICE SPEAKER TO SERVE AS AN ADVISORY MEMBER OF THE BOARD OF GOVERNORS:

CHAPTER VII
Board of Governors

Section 1. Composition (fourth paragraph)

The Speaker and the Vice Speaker of the House of Delegates shall be Advisory Members of the Board of Governors.

FMA Provisional Members

RECOMMENDATION NO. G-3
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

THAT THE HOUSE OF DELEGATES APPROVE AN AMENDMENT TO THE FMA BYLAWS TO ALLOW THE BOARD OF GOVERNORS, FOR GOOD CAUSE, THE FLEXIBILITY TO EXTEND THE TWO-YEAR TIME LIMIT NOW IMPOSED ON PROBATIONARY MEMBERS.

CHAPTER 1
Membership

Section 2. Classifications

4.C. Provisional (probationary) members of component societies pending acceptance into full component membership. Their Associate Membership shall terminate as of the end of the probationary period, as then fixed in the component society, immediately without any action by the Association or by any of its officers, without refund of any portion of dues and fees paid by the Associate Member, upon failure by the component society to advance its provisional member to full membership, or renew his provisional status, ~~but in no event shall such associate membership in the association exceed a period of two years from the date of the acceptance of a member on probation in a component society.~~ Associate Membership in the Association shall not exceed

a period of two years from the date of acceptance of a member on probation in a component society unless the Board of Governors shall for good cause extend such status.

Board of Governors Advisory Members --

There is a need to technically correct the bylaws to reflect the current name of the FMA-sponsored malpractice insurer and the Physicians State Licensing and Regulatory Authority.

RECOMMENDATION NO. G-4
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED AS AMENDED

THAT THE FOLLOWING AMENDMENT TO THE FMA BYLAWS BE APPROVED:

Chapter VII
Board of Governors

Section 1. Composition (third paragraph)

The Board at its discretion may select to serve on the Board of Governors in an advisory capacity, for a term of one year each, a representative from the Department of Health and Rehabilitative Services, from the State Board of ~~Medical Examiners~~ Medicine, and from the Board of Directors of the Florida Physicians' Insurance Company, all of whom must be member of the Association.

FMA Alternate Delegates --

RECOMMENDATION G-5
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING AMENDMENT TO THE BYLAWS WHICH PROVIDES ALTERNATE AMA DELEGATES THE PRIVILEGE OF THE FLOOR AT FMA HOUSE OF DELEGATES MEETINGS, AND DISCONTINUES THE PRIVILEGE OF FLOOR FOR "A REPRESENTATIVE OF THE FLORIDA MEDICAL ASSOCIATION MEDICAL STUDENT SOCIETY" SINCE THE FMA MEDICAL STUDENT SECTION HAS BEEN ESTABLISHED AND THAT SECTION IS AUTHORIZED A DELEGATE TO THE HOUSE OF DELEGATES.

CHAPTER IV
House of Delegates

Section 14. Privilege of Floor.

The privilege of the floor shall be restricted to seated delegates, officers, presidents of the county medical societies, members of the Board of Governors, AMA delegates and alternate delegates, past presidents, members of the Council on Specialty Medicine, council chairmen, ~~a representative of the Florida Medical Association Medical Student Society,~~ and AMA general officers and past presidents who are FMA members, except by permission of the presiding officer.

This privilege includes the right to make motions, provided they are seconded by a voting member of the house.

REPORT H
of the Board of Governors

(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

FMA Priorities 1986-1987

Traditionally, at the Board of Governors Meeting following the FMA Annual Meeting, the Board considers the Association's priorities for the coming year. In considering the 1986-87 priorities the Board was impressed that under the able and distinguished leadership of Dr. Luis Perez that the Association had made great strides in accomplishing many of the goals set out in the priorities for 1985-1986 and was mindful that each of those issues were carefully thought out and discussed in great detail by the Board. The Board felt that it would be most difficult to improve on those priorities since they continue to represent the most essential areas of concern facing the physicians of the State of Florida and their patients.

The Board, therefore, voted, except for the following additions, that the Association continue to pursue as the priorities for the Association for 1986-1987 those priorities established in the previous Association year. The status of the Association's activities in implementing the priorities is reflected throughout the Delegate's Handbook as well as in this summary:

1. During the next year the Florida Medical Association will rededicate and continue to emphasize the importance of medical ethics dealing with all aspects of the delivery of health care with special emphasis in dealing with the indigent and elderly population.

2. As part of the FMA's legislative priorities for the coming year, we will emphasize the need to deliver and appropriately finance quality and affordable health care for our indigent and elderly population (including a sovereign immunity protection).

3. During the coming year, we will work toward the full and active support of the national initiative to address the growing drug problem in the United States including our efforts to implement on a voluntary basis drug testing for each of the members of the Association and their staff.

FMA Priorities 1986-1987

1. The Florida Medical Association will continue to pursue additional measures, through the Florida Legislature or alternate approaches, if necessary, to contain and resolve Florida's professional liability insurance crisis.

2. The FMA will intensify activities in the area of membership development with special appeals directed at women physicians, residents-in-training and medical students. This program will:

 A. Recognize that membership **retention** of equal importance to membership recruitment;

 B. Encourage the formation of county medical society membership development committees in accordance with Board of Governors policy;

 C. Motivate women physicians to participate more actively in organized medicine and to assume leadership roles in organized medicine at the county, state and national levels;

 D. Continue to work toward the goal of having every physician recognize the importance of a full commitment to membership at all levels of the medical Federation. The major source of strength of any organization is a strong membership, which demonstrates that the organization is truly representative of the grassroots and whose voice will thus be stronger.

The FMA has participated in the AMA's "Invitation to Join" program for the past four years. However, such mass direct mail appeals to heterogeneous populations of physicians are not nearly as effective as campaigns directed at more homogeneous groups such as women physicians, residents, etc. For example, in June, mailings were sent to a select group **of women physicians who are also young physicians** (176 nonmembers of FMA, 152 nonmembers of AMA and 421 nonmembers of both for a total of 749) and received 37 requests for additional information. This is a return rate of about five per cent, more than double that usually achieved from more generalized "Invitation to Join" mailings.

During the 1987 Annual Meeting, FMA will sponsor, along with the American Medical Women's Association, a reception for women physicians.

FMA will also be sponsoring a business meeting and luncheon and AMA practice management

workshop for both FMA member and nonmember residents at the Annual Meeting. Soon after the Annual Meeting, a recruitment campaign among these physicians will be undertaken.

Due to organization of the Medical Student Section and membership campaigns conducted on the University of Miami and University of Florida medical school campuses, FMA student membership reached an all-time high of 157 this past April. No campaign was conducted at the University of South Florida, where membership numbered only four, but the members there planned to implement a recruitment strategy with the arrival of the new class this summer. The Medical Student Section Governing Council, which will meet for the second time during the Annual Meeting, has nominated several student members for appointment to FMA committees.

Membership retention is probably an activity best carried out as a component of virtually everything FMA does. Members should be made to feel they cannot afford to drop out. FMA has many valuable programs that make membership a value.

The Board of Governors, in June, approved a Committee on Membership Development recommendation that the FMA supply county medical society bulletins on a regular basis with articles about FMA accomplishments and efforts on behalf of membership. The recommendation was based on the belief that member physicians are more likely to read their county medical society bulletins than that FMA publications. Thus access to county medical society bulletin space would increase physician exposure to news about what the FMA is doing for its members.

The Committee on Membership Development has vigorously promoted replication of itself at the county medical society level. However, only about half of the component societies have membership committees. Starting in the fall, the committee will begin contact through personal visits to all county medical societies to promote formation of local membership development committees.

3. A long-range public relations program intended to build and maintain a positive image of physicians will be developed and implementation will be undertaken in the most expedient manner possible within the Association's financial capabilities. The program will promote the private practice of medicine and remind the public of the benefit it derives from the cooperative alliance of the private and public health sectors. The program will include:

 A. Incorporation of the five-point public relations program developed by the American Medical Association into the Association's public relations activities.

 B. Encouragement of each county medical society to form a public relations committee or develop some other mechanism to supplement the FMA program at the local level.

 C. Strengthening the FMA Speakers' Bureau and fostering the formation and function (through appropriate training programs) of similar bureaus within the county medical societies. Development and operation of ongoing leadership training programs for CMS officers.

 D. Development of appropriate programs to assist member physicians and their office staffs in improving communications and relationships with their patients. Portions of the risk management seminar conducted for physicians and their office staff are dedicated to this subject. Emphasis is placed on the importance of establishing a good working relationship with the physician's office staff as well as improving interrelations with the patient in trying to maintain good will and to give the proper perception that the office staff genuinely cares about the patient's well being.

 E. Coordination and integration of specialized public relations programs (e.g., the public health relations/education project) within the overall FMA public relations program, including allocation of staff time and fiscal resources.

 F. Assessment of the need for and, if appropriate, the development of a quarterly newsletter for members of the Florida Legislature, Florida's congressional delegation and other government officials as indicated.

 G. A plan for the rapid and accurate communication to news gathering organizations of the Association's reactions to news developments related to health care and the practice of medicine; and of the Association's views on current health care issues.

4. Additional steps will be taken toward full implementation of the Impaired Physicians Program with emphasis on identification and procurement of outside sources of funding; development of a harmonious and cooperative relationship with the Florida Department of Professional Regulation; and refinement of standards and procedures for approval or accreditation of participating treatment facilities.

5. The Association will strive for improvement in the internal communication of FMA news and other medical news to the branch offices, county medical societies, specialty groups and the membership through *The Journal,* the FMA monthly newsletter *FMA Today, The Legislative Bulletin, President's Memo* and other publications.

6. Members will be provided legal guidance through implementation of the telephone legal hotline. A comprehensive reference guide to help physicians understand the requirements of state law as it applies to the practice of medicine will be developed and made available to FMA members. This publication will be periodically updated.

7. The Association will develop and present to the Department of Professional Regulation, through the Board of Medical Examiners, an acceptable plan for the FMA to administer the new statutory risk management and continuing education requirement. The Association will also assume responsibility for administration of the present FMA Mandatory CME program and will undertake to formulate and administer a comprehensive program of CME courses for FMA members. This priority has been achieved. During the past Association year, over 25 risk management seminars were conducted and have been attended by over 5,000 physicians. The risk management seminars conducted by the Florida Medical Association in cooperation with the Florida Physicians Insurance Company is five hours in length and does satisfy the state five-hour risk management requirement. This program has been very well received by membership. Twelve seminars have been scheduled for the fall.

8. The AMA/GTE Medical Information Network (MINET) will be marketed aggressively among the membership and the county medical societies.

9. Close surveillance will be maintained on the statewide peer review organization (PRO), and any evidence of irregularity or inequity will be documented and reported to the appropriate authorities. The FMA's Committee on Peer Review Organizations has maintained close surveillance of the PRO activities. The Committee has regularly reviewed individual cases submitted by physicians who have had admissions denied by the PRO as well as have maintained on an ongoing basis liaison with the PRO in order to help resolve unjustified admission denials on behalf of individual physician members. The Committee is continually conducting case reviews and has been meeting frequently throughout the year to address individual problems brought to their attention by the FMA membership.

10. The Medical Practice Act and all other health-related state laws that are scheduled to expire on October 1, 1986, will be scrutinized and appropriate recommendations regarding their reenactment will be made to the Legislature.

11. The Association will continue to resist the unqualified efforts of allied health groups to intrude further into the practice of medicine through legislative and other means.

12. An aggressive medical economics program will continue to be pursued. Special attention will be given to implementation of Resolution 85-2 (Alternative Delivery Systems) and Resolution 85-4 (Workers' Compensation); development of a physicians contracting guide and the 1986 Relative Values Studies; examination of prepaid Medicaid plans; monitoring the development of the DHRS Primary Care Program; and generating recommendations regarding indigent care in Florida. This priority has been well achieved by the Association during the 86/87 year. With regards to implementation of Resolution 85-2, Alternative Delivery Systems, the FMA has undertaken a major feasibility study on prepaid plan activity in Florida as well as retained Judith Mattson of Judith Mattson, Inc., to assist in developing alternatives and mechanisms for our membership to utilize in addressing the development of alternative delivery systems in Florida. As a result, several recommendations were considered by the Board. Based on the results and observations of the investigative phases of the development of the business plan for a management services company prepared by Judith Mattson, Inc., it was recommended that a program should be implemented that would aid physicians in their managed care relationships which is not of itself any type of

statewide managed care program. It was also recommended that the FMA develop a Florida medical management services company that is a self-sustained entity designed to address the day-to-day business concerns of the practicing physicians in a competitve health environment, and that the FMA approve continuation of the initiative of the development of a management services company through authorization of funding to complete the final developmental stages of the proposed company. Other recommendations included that the FMA consider the incorporation of current affiliated business organizations, activities and services in the Florida medical management services company to improve the cost and effectiveness for each related activity within the organization of the management services company. As a result of the recommendations submitted by the Ad Hoc Committee on Prepaid Plans, the Executive Committee of the Board of Governors recognized that these recommendations needed to be utilized as guidelines in the ongoing development of FMA's membership services activities. It was recommended by the FMA Board of Governors that the FMA accelerate the activities of FLAMEDCO, Inc., to implement the recommendations outlined in the Committee's report and to authorize the Executive Vice President with the approval of the Treasurer to implement these programs with necessary staff with the exception of those programs currently being administered by the Florida Physician's Association.

The Physicians Contracting Guide was completed by FMA Legal Counsel to assist physicians in contracting with prepaid plans and other alternative delivery systems as well as the fact that the Florida Physicians Association continues to review individual physician contracts for FMA members. During the Association year, the 1986 Florida Relative Value Studies was completed. The Committee on Relative Value Studies is currently updating the 1986 edition to incorporate all the changes that have occurred since new data has become available and the AMA CPT-4 book has been updated. The Florida Medical Association, during this Association year, was successful in getting legislation passed to provide for proper funding for indigent care. The funding is to be utilized in assuring that more money is spent in the primary care area of medicine rather than in the acute care centers which has historically been the case in Florida. The county public health units will coordinate the health care through the primary and acute care areas.

The Florida Medical Association Committee on Workers' Compensation met several times during this Association year to address the inequities found in the Workers' Compensation fee schedule. During this past year, the FMA encountered a major obstacle due to the insurance commissioner's office declining to accept the data that had been developed by the Office of Medical Services in determining what level of reimbursement should be given to physicians in the Workers' Compensation fee schedule. As a result, an increase that was granted during 1986 in the fee schedule has not been put into effect because the Office of Medical Services has had to recalculate the entire Workers' Compensation data base.

13. The FMA will develop a program to assure that each hospital medical staff exerts its proper influence in all care-related issues at its hospital.

14. Continued efforts to develop among FMA members an awareness of their individual responsibility for becoming actively involved, through organized medicine, in the decisions that will be made by the Legislature and other governmental bodies affecting the mechanism and level of health care delivery in Florida and throughout the county including, but not limited to, health care financing and systems of health care delivery; i.e., Health Maintenance Organizations, Individual Practice Associations, Preferred Provider Organizations, Diagnostic Related Groupings, health care competition, utilization review, peer review mechanisms, and other cost containment initiatives.

The Council on Medical Economics as well as the Florida Medical Foundation's Committee on PMUR have regularly addressed these issues. Throughout the Association year, several articles were printed in both **E.T.** and **FMA Today** regarding the Medicare financing system, the development of prepaid plans in Florida, proposed DRG regulations in Washington, and the effect of health care competition on the individual private practice of medicine. Several articles were written in **The Journal** to educate the physicians on the changing practice patterns and the effect of competition on the fee-for-service system.

15. The FMA will cooperate with the Florida Physicians' Association in working to initiate positive programs supporting the intent of the House of Delegates at the time of generation of the Florida Physicians' Association.

16. The FMA will continue to pursue the implementation of the previous action of the Board to provide administrative services to specialty groups.

17. Pursue increased liason with voluntary health organizations and consider development of objectives of mutual interest. The Council on Hospital Medical Staffs and the Council on Medical Economics has historically established liaison with various voluntary health organizations which include but are not limited to the Florida Hospital Association, the Florida Nursing Association, the Florida Osteopathic Association, the Florida Dental Association, the Medical Group Management Association, the Florida League of Hospitals, the Florida Voluntary Hospital Association, Department of Professional Regulation, and the American Medical Association. Both these Councils were intricately involved in maintaining liaison with these affiliated organizations to work on issues of common concern as well as to obtain factual information that would assist the FMA in its research efforts.

18. The FMA will continue its commitment to the quality and access for medical care for all citizens of Florida. This priority was well achieved during the 1986/87 Association year because of the FMA's involvement in securing the passage of indigent care legislation. Medicare reimbursement has become a major issue in Florida because of the budget reductions being placed on the program by Congress. In addition to these reductions, Congress enacted the Omnibus Budget Reconciliation Act of 1986 which stated that physicians who do not participate in the Medicare program are not allowed to charge a Medicare patient above a certain maximum allowable actual charge (MAAC). The FMA has vehemently opposed this legislation and has provided ongoing assistance to its membership with regards to problems they have encountered with reimbursement pertaining to Medicare allowances. In addition, the Association is working closely with the AARP and other affiliated retired organizations in order to educate them on the current levels of reimbursement that Medicare pays for services as well as trying to ensure that mandatory Medicare assignment is not enacted.

19. The Association will continue to actively support political education projects for FMA members on the state and national levels and continue to stress the importance of being knowledgeable in respect to the physician's role in the legislative process concerning health care issues.

20. To continue to explore the expansion of the FMA Auxiliary's role in the activities of the FMA.

Legal Activities

1. Tort Reform and Insurance Act of 1986.

The Tort Reform and Insurance Act of 1986 became effective July 1, 1986. Shortly after it became effective, the insurance industry, followed by the trial bar, filed a lawsuit in circuit court in Tallahassee to declare the law unconstitutional. The thrust of the arguments in respect to the act were that it violated the single subject requirement of the Florida Constitution; that it deprived injured persons access to the courts for redress of injuries; and that the act deprived injured persons rights in violation of the Equal Protection Clause of the Florida Constitution. The Florida Medical Association intervened in this lawsuit as a defendant to defend those provisions of the case dealing with tort reform and the single subject issue. This case proceeded through trial, and in October of 1986 the circuit court in Tallahassee rendered an opinion upholding the constitutionality of the act except for a provision of the insurance regulation portion dealing with the "special credit" that was intended to be refunded on policies written prior to July 1, 1986. Subsequent to the circuit court decision, the Academy of Trial Lawyers and the insurance industry took an appeal of this case to the First District Court of Appeal which, in turn, immediately certified the case to the Supreme Court of Florida. Briefs were filed during the month of December, 1986, and in January, 1987, and the case was orally argued on January 30, 1987. On April 23, 1987, the Supreme Court handed down its opinion upholding the entirety of the circuit judge's ruling except for the provision of the Act placing a cap of $450,000 on noneconomic damages. The Supreme Court found this provision to be in violation of the Florida Constitution in respect to access to courts and trial by juries. Subsequent petitions for rehearing were filed but denied by the Supreme Court. Research was done and concluded that there was no basis on which to appeal this decision to the federal courts of the United States of America.

2. Florida Society of Ophthalmology and the Florida Medical Association v. The Department of Professional Regulation, State Board of Optometry, et al.

The Board of Governors, in September, 1986, authorized the FMA to support the Florida Society of Ophthalmology in a lawsuit in respect to the authorization for prescription drugs by optometrists that was contained in the the Optometric Practice Act enacted by the 1986 Florida Legislature. The Board of Governors authorized FMA's financial obligation in respect to this matter to be set at 10 percent of the legal fees incurred, to a maximum not to exceed $30,000. This funding was authorized, subject to the availability of funds and, further, that FMA General Counsel be authorized to actively participate and monitor this lawsuit.

The lawsuit has been filed and has gone through a number of procedural aspects regarding the above-referenced act. At this point in time, the lawsuit is still in the discovery stage and no time has been set for a trial on the merits. As the case proceeds, we will be working with Attorney Ken Ortell of Tallahassee, who has been retained by the Florida Society of Ophthalmology.

3. FTC Matter

The Florida Medical Association has assisted one of its specialty societies during the past year in respect to an inquiry initiated by the Federal Trade Commission into activities of that society. At this point in time, no charges have been brought against the society; and the FMA is continuing to work with the Federal Trade Commission in resolving this matter.

REPORT J
of the Board of Governors

(Reference Committee No. III, IV, V, pages 1062, 1068, 1071)

HOUSE ACTION: ADOPTED

1986 House of Delegates Referrals & Resolutions

The Board reviewed the proceedings of the House of Delegates and items and resolutions requiring additional study and/or action were referred to the appropriate councils and committees. The Board also reviewed resolutions adopted by the House and those not adopted by the House but referred to the Board for review.

The following report summarizes the status of the actions taken by the Board regarding each of these items. This summary includes an updated report on disposition of resolutions enacted by the House of Delegates in 1986 in compliance with Resolution 86A-14.

Resolution 86A-14 introduced by the Dade County Medical Association resolved that beginning with the 1987 Annual Meeting, the Board of Governors ensure that information regarding the disposition of resolutions referred to it the previous year be distributed to each component county medical society, delegate and alternate no later than sixty days prior to the opening session of the House of Delegates. A report was submitted by the Board to county medical societies, delegates and alternates in compliance with this resolution.

In addition, actions regarding the policies by the House of Delegates appear in the various council and committee reports as well as in this and other reports of the Board of Governors in the Delegates' Handbook.

In compliance with Resolution 86A-14 adopted by the House of Delegates at the 1986 Florida Medical Association Annual Meeting, the Board of Governors is pleased to provide a report regarding the disposition of resolutions adopted by the House or referred to the Board in 1986. Each resolution is listed in numerical order according to its appearance in the 1986 House of Delegates Handbook.

Resolution 86A-1 — Vice Speaker (Broward CMA)

Resolution 86A-1 resolved that the Vice Speaker of the House of Delegates of the Florida Medical Association be made an Advisory Member of the Board of Governors. This resolution was adopted and the appropriate amendment to the FMA Bylaws is included in a separate section of the Board's report to the House of Delegates.

Resolution 86A-2 — Nasogastric Tubes (Sarasota CMS)

Resolution 86A-2 resolved that all life sustaining mechanisms, including nasogastric tubes, be administered only by order and under the direction of the patient's personal physician.

The resolution was referred to the Judicial Council which recommended adoption by the Board of Governors. The resolution was adopted at the January 31, 1987, meeting of the Board of Governors.

Resolution 86A-3 — Unified Membership With the American Medical Association (Palm Beach CMS)

Resolution 86A-3 resolved that the Florida Medical Association urge all physicians to join the American Medical Association, and that the Board of Governors study the advantages and disadvantages of unified AMA membership and report their findings and recommendations to the 1987 House of Delegates.

The FMA Committee on Membership Development reviewed materials supplied by the AMA and four "unified" states and conducted a survey of county medical societies. It was determined that mandating AMA membership for all FMA members would not be advisable at this time. However, the Committee recommended that all FMA members be strongly encouraged to maintain AMA membership on a voluntary basis.

RECOMMENDATION J-1
(Reference Committee No. III, page 1062)

HOUSE ACTION: NOT ADOPTED

THE BOARD OF GOVERNORS RECOMMENDS THAT THE RESOLUTION 86A-3 NOT BE ADOPTED.

Resolution 86A-4 — Competition in Medicine (Palm Beach CMS)

Resolution 86A-4 resolved that the Florida Delegation to the American Medical Association introduce a resolution at the 1986 Interim Session of the AMA House of Delegates asking the AMA to serve as a clearinghouse for information and strategies that local physician groups can use to educate the public concerning the advantages and disadvantages of various forms of health care delivery and publicize this service to the entire federation.

This resolution was submitted to the AMA House of Delegates and was referred to the AMA Board of Trustees as Resolution 19, the substance of which was contained in Board of Trustees Report NN entitled "Potential of AMA Involvement in IPA Activity." Report NN recommends that the AMA not pursue the development of a nationwide health care delivery system. However, it describes AMA activities in this area including maintenance of a delivery systems clearinghouse, development of informational forms, and establishment of new consulting activities. The reference committee to which Resolution 19 was referred stated that the AMA clearinghouse currently being implemented as the result of Report NN will be continually evaluated and urged that the Board of Trustees give special consideration to the inclusion of patient information materials. Hence, Report NN was adopted in lieu of Resolution 19 by the AMA House of Delegates.

Resolution 86A-5 — Capitation as a Payment Mechanism for Medicare (Palm Beach CMS)

Resolution 86A-5 resolved that the Florida Medical Association urge the United States Congress, the Health Care Financing Administration, and the President to immediately halt the expansion of federal capitation programs for Medicaid, Medicare and Champus until the problems that have surfaced in Florida and elsewhere around the country can be thoroughly evaluated; and further, the Florida delegation to the American Medical Association should submit the resolution to the 1986 AMA Interim Session in December.

This resolution was introduced as Resolution 18 to the AMA House of Delegates which adopted the resolution and referred it to the AMA Board of Trustees. The FMA has gone on record in opposing major Medicare reforms that Congress is considering in Washington. This includes strong opposition in placing radiologists, anesthesiologists and pathologists under the current DRG system. The FMA and AMA have made recommendations to Congress with regards to providing adequate reimbursement for physicians who provide Medicare services. Physicians are currently receiving anywhere from 50 to 55

percent actual reimbursement for a particular service they provide. The Florida Medical Association works in concert with the AMA in making legislative visits to Florida Congressmen and Senators to lobby for expanded funding and improvement in the overall administration of the Medicare program.

Resolution 86A-6 — FMA Membership as a Requirement for Licensure (Orange CMS)

Resolution 86A-6 resolved that the FMA House of Delegates express its concern that there is a need for physicians to have adequate power for self-discipline, and request that the Board of Governors conduct an appropriate study of the desirability of requesting that the state legislature make FMA membership a requirement for licensure with a report of the study and recommendation by the Board of Governors to be submitted to the House of Delegates at the annual meeting in 1987.

After careful study and assistance from AMA General Counsel Kirk B. Johnson, the Committee on Membership Development's recommendation to the Board of Governors was adopted which urged that Resolution 86A-6 **not** be adopted but the Florida Medical Association pursue any means that might be appropriate to broaden and enhance the authority and jurisdiction of the FMA and AMA Judicial Councils, as well as county medical society judicial councils, as a means of strengthening the medical disciplinary process.

RECOMMENDATION J-2
(Reference Committee No. III, page 1062)

HOUSE ACTION: NOT ADOPTED

THE BOARD OF GOVERNORS RECOMMENDS THAT RESOLUTION 86A-6 NOT BE ADOPTED.

Resolution 86A-9 — Labeling for Prescription Drugs (Lee CMS)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-9 resolved that the FMA intercede with the Florida Board of Pharmacy to have instituted the requirement that all prescriptions for trade name drugs when filled with generic drugs be labeled in the following or similar manner:

Drug Prescribed: "Trade Name"
Drug Dispensed: "Generic Name"

And, if the FMA fails in these negotiations with the Pharmacy Board, then the FMA will attempt through the legislative process to accomplish this goal.

In communication with the Board of Pharmacy it was determined that in 1980 labeling guidelines were adopted by the Board of Pharmacy which would accomplish the intent of Resolution 86A-9. However, the Board of Pharmacy has not made these guidelines binding. Therefore, the intent of this Resolution has not been achieved. The FMA will therefore seek to carry out the intent of Resolution 86A-9 through appropriate legislative action during the 1988 session of the Legislature.

Resolution 86A-11 — County Medical Society Judicial Council (Dade CMA)
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-11 resolved that the Florida Medical Association explore the formation of judicial councils at the county medical society level to implement under the auspices of the State Board of Medicine an aggressive program to uphold and promote the highest standards of medical and professional conduct of physicians.

The Resolution was referred to the Judicial Council which is seeking additional information prior to a final determination.

Resolution 86A-13 — Proceedings of the House of Delegates (Dade CMA)
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-13 resolved that beginning with the 1987 Annual Meeting, the format of the proceedings of the House of Delegates as published in the **Journal of the Florida Medical Association** be revised to be consistent with that utilized by the American Medical Association.

The Resolution will be implemented with the 1987 House of Delegates proceedings.

Resolution 86A-14 — House of Delegates Referrals (Dade CMA)
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-14 resolved that beginning with the 1987 Annual Meeting, the Board of Governors ensure that information regarding the disposition of resolutions referred to it the previous year be distributed to each component county medical society, delegate and alternate no later than sixty days prior to the opening session of the House of Delegates.

A report on resolutions considered by the House of Delegates in 1986 was submitted as required.

Resolution 86A-15 — Not-for-Profit Liability (Dade CMA)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-15 resolved that the Florida Medical Association place as a goal for its 1987 Legislative Program the enactment of legislation patterned after other state statutes which, by use of Good Samaritan or other statutes, provides exemptions from liability to not-for-profit professional associations and their directors and officers.

Committee Substitute SB 1096, 965,954 provides liability protection for not-for-profit and for-profit professional associations and officers and directors.

Resolution 86A-16 — Sales Tax Exemption (Dade CMA)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-16 resolved that any consideration of the imposition of sales tax on professional services of physicians in Florida be aggressively opposed by the Florida Medical Association.

Committee Substitute for Senate Bill 777 enacted in the 1987 Session of the Florida Legislature contains a provision for continuing exemption of health care professional services from sales tax.

Resolution 86A-17 — Physically Challenged Physicians (Dade CMA)
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-17 resolved that the Florida Medical Association develop a program for physically challenged physicians.

The resolution was referred to the Committee on Impaired Physicians which recommended that the Florida Medical Association endorse the concepts contained in Resolution 86A-17 and consider establishing a special committee to address the problems of physically challenged physicians. At the January 1987 meeting of the Board of Governors, the recommendation was referred to the Executive Committee. This resolution is currently under review by the Committee on Impaired Physicians for possible inclusion in the Committee's activities.

Resolution 86A-18 — Sample Medication (Dade CMA)
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-18 resolved that the Florida Medical Association Delegation to the American Medical Association introduce a resolution directly to the AMA to aggressively oppose any federal legislation that would in any way limit the use of sample medications by the physicians of the United States because existing laws are adequate to prevent misuse.

The resolution was introduced to the AMA as Resolution 17. A substitute Resolution 17 was adopted by the Reference Committee which addressed the issue of sample medications included in three other resolutions. Resolution 17 was adopted.

Resolution 86A-19 — Rally in Washington, D.C. (Dade CMA)
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-19 resolved that the Florida Medical Association petition the American Medical Association to organize and coordinate a mass rally and legislative meeting of its nationwide membership, and other interested parties, in Washington, D.C., in 1987 to influence passage of favorable tort reform legislation before the Congress of the United States.

The resolution was introduced to the American Medical Association as Resolution 12. Resolution 12 was not adopted.

Resolution 86A-20 — Contingency of Patient Compensation (Dade CMA)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-20 resolved that the Florida Medical Association add to its legislative goals that of promoting a law to guarantee a "contingency patient compensation" for injured patients who win jury awards because it has been reliably estimated that about 28 cents out of every dollar paid in premiums really get to the injured patient and about 60 cents for legal fees, and that the fee schedule be based on a graduated scale which will channel most of the award to the plaintiff such as follows:

a) If the award is $50,000 or less — 60% should go to the injured patient;

b) If the award is greater than $50,000, 67% of any amount from $50,000 to $100,000 should go to the injured patient;

c) If the award is greater than $100,000, 75% of any amount from $100,000 to $200,000 should go to the injured patient;

d) If the award is over $200,000, 90% of any amount over this should go to the injured patient;

e) It is understood that all legal costs will be treated as has been the custom previously.

Committee on State Legislation members suggested that this concept warranted further review before specific implementation activities are initiated. In addition, legislative pursuit of a Barron-type plan establishing a schedule of benefits for injured parties substantially satisfies the spirit of Resolution 86A-20. The Board of Governors concurred in the opinion of the Committee on State Legislation that removal of professional liability from the tort reform system results in a greater degree of equality and efficiency.

Resolution 86A-21 — Mediation Panels (Dade CMA)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-21 resolved that the Florida Medical Association aggressively pursue all legislative and/or constitutional paths to the reinstatement of mediation panels.

Committee on State Legislation members felt that there is a need to explore the reestablishment of medical mediation panels. However, before the FMA seeks implementation of this resolution, an effort should be undertaken to explore the efficacy of mediation panels as they relate to professional liability. Therefore, at the November 15, 1986, Committee on State Legislation meeting, Motion 86-4-7 was adopted "to request that the FMA Board of Governors study the feasibility of reinstating medical mediation panels include the many variations of the mediation panel concept."

Resolution 86A-23 — Education and Licensure (Dade CMA)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-23 resolved that the Florida Medical Association encourage the Florida Legislature to provide that requirements for licensure include adequate premedical education, a medical school curriculum deemed adequate in duration, and in course content, and include at least one year of appropriate postgraduate training.

Upon review of the current Medical Practice Act, the Committee on State Legislation felt that the statute provides for compliance to the specific resolves in Resolution 86A-23. Specifically, the 1986 rewrite of the Medical Practice Act provides for the following:

— requires that individuals applying for licensure by examination must demonstrate English competency and that graduates of uncertified foreign medical schools must have three additional years of post-graduate training.

— authorizes the Department of Professional Regulation to provide for the evaluation and certification of foreign medical schools.

This issue is not referred to in the 1987 Council on Legislation Annual Report, however, it was cited in the June 20, 1986, Supplemental Report of the Council on Legislation to the Board of Governors.

Resolution 86A-24 — Licensure and Assignment (Dade CMA)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-24 resolved that the Florida Medical Association take all steps necessary to be prepared to challenge the authority of the Florida Legislature to enact legislation tying licensure to acceptance of assignment.

The Florida Medical Association was successful in thwarting all attempts to mandate acceptance of any third-party payor assignment as a condition of licensure. The FMA is currently working very hard in developing alternatives to mandatory Medicare assignment. A meeting was held with representatives from the Council on Medical Services and Council on Medical Economics with the Executive Director of the Connecticut State Medical Society for the purpose of discussing the current status of mandatory assignment in Florida and what alternatives the FMA has available to them, such as those that have been successful in Connecticut, in avoiding legislation that would tie mandatory Medicare assignment to licensure. In addition, there are plans to establish a joint committee with representatives from the AARP and other retirement organizations with representatives to work together in developing an alternative to address the major concerns addressed by the Florida AARP, that being of affordability and accessibility to quality health care.

Resolution 86A-25 — Health Insurance Requirements (Dade CMA)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-25 resolved that the Florida Medical Association immediately prepare to introduce legislation in the Florida Legislature that will require that all employers offering health benefit plans to their employees also include medical insurance covering fee-for-service medical care; and further that the Florida Medical Association, should such legislation be introduced, mount a statewide campaign

to ensure passage of this legislation by educating the public and obtaining public support; and further that the AMA seek introduction of similar legislation in the U.S. Congress.

The Florida Delegation to the American Medical Association introduced Resolution 14. A substitute Report XX and Resolution 79 on the same subject were adopted. The Committee on State Legislation recommended that the concept embodied in Resolution 86A-25, Health Insurance Requirements, be incorporated in the FMA's 1987 legislative program. However, the Association was unable to enact legislation to conform to Resolution 86A-25 and will continue to pursue this goal.

Resolution 86A-26 — Reduced Fee School Examinations (Dade CMA)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-26 resolved that the Florida Medical Association encourage each county medical society to provide a mechanism for all counties within their jurisdiction whereby school physical examinations can be made more available to low income individuals through qualified physicians; and further that the Board of Governors develop an appropriate recognition for those physicians who give of their time to serve the communities of Florida in this important area; and further that the FMA pursue strengthening of the existing Florida Good Samaritan Law to provide better protection for physicians donating their time in conducting school sports participating physical examinations, and physicians donating their time on or off the field for junior high and high school sports programs.

The Board of Governors at its January 1987 meeting approved that the Florida Medical Association broaden the application of the third resolve of FMA Resolution 86A-26 (reduced fee school examinations) to afford greater liability protection to physicians who conduct pre-school physical examinations free of charge, as well as those who perform participation (athletic) examinations; and further, that the FMA consider recommending to these physicians that they enter outside provider service contracts with the Department of Health and Rehabilitative Services in order to gain protection under the State's sovereign immunity.

The Board also approved that the Florida Medical Association, upon the recommendation of the county medical societies, award certificates of volunteer participation to those FMA members who during the previous school year provided school entry and athletic physical examinations free of charge; further, that this policy also apply to physicians who donate their time for "Special Olympics" and similar programs; and further, that these physicians be further recognized through publication of their names in a special pamphlet to be distributed at the Annual Meeting each year.

Information on Resolution 86A-26 has been widely distributed through **FMA Today, E.T.**, the **Journal of the Florida Medical Association,** and an April 14, 1987 memorandum to all county medical society secretaries from FMA Secretary Henry M. Yonge, M.D.

The Committee on State Legislation reviewed the language contained in Resolution 86A-26 and felt that the first two resolves did not require legislative action. However, the third resolve was recognized by the Committee as a legislative activity. Therefore, the Committee on State Legislation recommended to include in the 1987 legislative program strengthening the existing "Good Samaritan Law" to provide better protection for physicians donating their time in conducting school sports participation physical examinations, and physicians donating their time on or off the field for Jr. High and High School sports programs. However, legislation providing this protection was defeated during the 1987 Session. The Committee will continue its efforts to achieve this legislative objective during the 1988 session.

Resolution 86A-28 — Insurance Claim Payments (Dade CMA)
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED

Resolution 86A-28 resolved that the Florida Medical Association request that the Insurance Commissioner institute and enforce a reasonable reimbursement period for payment of claims to the physician (30 days from date of receipt of insurance claim to date of payment to the physician by Florida registered insurance carriers). Prevailing interest rate shall be added to the base charge for failure to comply.

This resolution is currently being researched by FMA Staff. The current law pertaining to assignment of insurance claim payments does not specifically state the time period in which a clean claim should be reimbursed. It does state that it should be done within a reasonable period of time. The ten major health insurance companies have been contacted and are participating in a survey to assist the FMA in finding out procedures of individual insurance companies in reimbursing claims. Some of the information being compiled relates to the extended amount of time it takes to process a claim that is not considered "clean." This information will be completed and available at the time of the annual meeting. In addition, the Council on Medical Economics has been studying this issue and will be developing a recommendation with regards to specific policy that should be established regarding prompt insurance claim payments.

Resolution 86A-29 — Medicare PRO Advisory (Polk CMA)
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED

Resolution 86A-29 resolved that the Florida Medical Association urge all physicians in Florida to warn their Medicare patients that due to PRO policy the cost of their hospitalization may not be paid, either in whole or in part, by Medicare, if a retrospective denial is issued by the PRO, but that this possibility has no relationship to their physician's opinion, experience, or judgment.

This information has been published regularly in **FMA Today** and **E.T.** and will continued to be disseminated as changes in the policy occur.

Resolution 86A-30 — Generic Substitutions
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-30 resolved that the Florida Medical Association with members of the Florida Congressional Delegation, the AMA, and FDA officials seek legal remedies in updating the 1938 Food, Drug and Cosmetic Act to permit proper labeling and classification of the non-therapeutically equivalent drugs.

Florida Delegation to the American Medical Association introduced Resolution 15 on the subject which was referred to the Board of Trustees for a report back to the House of Delegates.

Resolution 86A-31 — Medicare Claims Rejection (Pinellas CMS)
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED

Resolution 86A-31 resolved that the Florida Medical Association, the American Medical Association and the Florida Congressional Delegation enter into serious negotiations with Health and Human Services, Health Finance Administration and Blue Cross/Blue Shield of Florida to eliminate Medicare claims rejection for unsound medical reasons, and further that the Florida Medical Association contact Blue Cross/Blue Shield of Florida, Inc., and inform them as to the current standards of medical care and request that they seek the modification of the policy of denial of payment of concurrent care by more than one physician by whatever means are feasible, and further that the Florida Medical Association use its public relations facilities to educate the senior citizens as to the causes of Medicare payment delays or refusals, and further that the Florida Medical Association educate physicians on the proper preparation of claim forms in the cases where concurrent care has been provided.

Portions of this resolution have been achieved through communication with Blue Cross/Blue Shield of Florida, Inc. The public relations program pertaining to the subject matter is being developed. FMA Staff met with representatives of Blue Cross/Blue Shield of Florida, Inc., regarding the concurrent care issue. In addition, several specialty societies have established a committee with Blue Cross/Blue Shield of Florida, Inc., to serve in an advisory role to provide input to issues that affect physicians and their patients. The FMA Council on Medical Economics has also recommended that a committee be established composed of various specialties in the state to also serve in advisory capacity in addressing the current standards of medical care and in potential modifications of the HCFA policy pertaining to denial of payment for concurrent care.

Resolution 86A-32 — Fiscal Note to Resolutions
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-32 resolved that all future proposals and recommendations from the Board of Governors, Councils and Committees, and Resolutions presented to the House of Delegates of the Florida Medical Association include a fiscal note.

Implemented with the assistance of the FMA Department of Finance.

Resolution 86A-33 — Regulatory Pain and Sleeping Medications
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-33 resolved that the Florida Medical Association develop appropriate prescribing guidelines for use by physicians for the treatment of patients suffering from severe chronic pain, and further that after prescribing guidelines are developed, they are presented to the appropriate state governmental agency as the community standard in Florida for the treatment of these types of patients, and further that these prescribing guidelines be reviewed and modified as appropriate annually by the Florida Medical Association to assure that they are current with existing medical practice in Florida.

The resolution was referred to the Council on Medical Services which recommended that it not be adopted. However, a proposal for mandatory continuing medical education in pain management has been referred to the Council on Scientific Activities for review.

RECOMMENDATION J-3
(Reference Committee No. III, page 1062)

HOUSE ACTION: NOT ADOPTED

THE BOARD OF GOVERNORS RECOMMENDS THAT RESOLUTION 86A-33 NOT BE ADOPTED.

Resolution 86A-34 — Contingency Fees for Frivolous Lawsuits
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-34 resolved that the Florida Medical Association seek the enactment of legislation requiring an attorney who files a liability suit on a contingency fee basis, to pay a portion of the defendant's court cost if the suit is lost.

The Committee on State Legislation suggested that the concept embodied in Resolution 86A-34 warranted further review before final inclusion in the FMA's legislative program. A motion was made and unanimously adopted to "further review the concept embodied in Resolution 86A-34-Contingencies for Frivolous Lawsuits, before specific implementation activities are initiated." In addition, the Committee on State Legislation was aware of Section 57.105, F.S., that instructs the court to award reasonable attorney's fees to be paid to the prevailing party in equal amounts by the losing party and the losing party's attorney. A report and recommendation will be submitted to the Board prior to the 1988 session of the Legislature.

Resolution 86A-35 — PRO Programs (Capital CMS)
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED

Resolution 86A-35 resolved that the Board of Governors of the Florida Medical Association continue monitoring of the Florida PRO and resolution of problems related to the operation of that organization, and that the House of Delegates instruct its AMA Delegates to request the American Medical Association, in conjunction with the American Hospital Association, to work with appropriate federal officials

in an attempt to resolve problems with PROs, and further that the Florida Medical Association strongly recommends that a physician of the Professional Foundation for Health Care, Inc., the statewide PRO, review all denials, and further that reconsideration of denials be done by subspecialty peers at the reconsideration level.

This resolution has been implemented. The FMA Committee on PRO is regularly monitoring the activity of the PRO and is addressing individual complaints submitted by the membership.

Resolution 86A-36 — Investigation of Self-Insurance Trust (Dade CMA)
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-36 resolved that the Florida Medical Association express its concern over the widespread use of assessable self insurance trusts as a means of physicians maintaining professional liability insurance; and further that the Florida Medical Association request that the Florida Department of Insurance conduct a formal investigation of all self insurance trusts opening in Florida to ensure that physicians and other professionals will not fall victim to disastrous consequences.

This resolution was referred to the Executive Vice President and President for implementation.

Resolution 86A-38 — Expert Witness
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-38 resolved that the Florida Medical Association promote legislation that an expert witness be licensed and actively practicing in the state and have practiced in his specialty for at least the past four years, with less than 10% of his income from medical practice in a given year being derived from activity as an expert witness, prior to his giving testimony in court or by deposition in said state in which an alleged incident had occurred.

The Committee on State Legislation, upon review of this resolution, suggested that the concept warranted further review before final inclusion in the FMA's legislative program. Therefore, Motion 86-4-9 was adopted at the November 15, 1986 Committee on State Legislation meeting "to further review the concept embodied in Resolution 86A-38-Expert Witness, before specific implementation activities are initiated."

Resolution 86A-39 — Medicare Toll-Free Access (Dade CMA)
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED

Resolution 86A-39 resolved that the Florida Medical Association urge Blue Cross/Blue Shield of Florida, Inc., to make a 24-hour toll-free phone line for use by physicians and hospitals to determine if a patient's Medicare benefits have been transferred to a HMO or CMP.

This resolve has been accomplished.

Resolution 86A-40 — 1986 Constitutional Initiative (Dade CMA)
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Resolution 86A-40 resolved that the Florida Medical Association, preferably in concert with the Florida Coalition for Liability Reform, immediately initiate all activity necessary to achieve numerous constitutional initiatives in 1988 regarding professional liability; and further that such initiatives be developed to: 1) place further limits on awards for general damages, 2) abolish the doctrine of joint and several liability, 3) establish a contingency patient compensation scale, and 4) institute the mandatory use of

medical mediation plans.

After extensive and thorough discussion, the Committee on State Legislation felt that undertaking a constitutional initiative would be an extremely costly and time consuming activity. Therefore, it was felt by the Committee that the FMA determine the extent of support from the general membership before the essence of Resolution 86A-40 is implemented. A motion was adopted at the January 4, 1987 Committee on State Legislation meeting "to recommend that the FMA Board of Governors adopt the four elements embraced in Resolution 86A-40-Constitutional Initiative, as legislative objectives at this time, and furthermore, that approval of this resolution be based upon substantial support from the general membership of the FMA in order to initiate the spirit of the resolution."

Resolution 86A-41 — Vaccine Related Injury Legislation (Dade CMA)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-41 resolved that the Florida Medical Association actively seek the passage of state "no fault" legislation for vaccine related injuries which are due to vaccines required by state law or regulation.

The Committee on State Legislation, aware of recently passed federal legislation known as the "Vaccine Compensation Law", felt that the majority of the concerns expressed by Florida physicians were remedied at this time. In view of the passage of this federal legislation, the Committee felt that no further action was necessary at the State level as it relates to vaccine-related injuries.

Resolution 86A-44 — Malpractice Coverage for Physicians Providing Indigent Care
(Palm Beach CMS)
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Resolution 86A-44 resolved that the Florida Medical Association support extension of the State of Florida limited sovereign immunity to include physicians on contract with County Health Departments.

This resolution was incorporated as a recommendation from the Committee on Indigent Care and approved by the Board of Governors at its October 14-19, 1986 meeting. Subsequently, appropriate statutory language was developed and incorporated in House Bill 414 by Rep. Alzo Reddick, D-Orlando, and Senate Bill 247 by Senator George Stuart, D-Orlando. Although the concepts of primary care through county public health units on contract with the private medical sector and other features of House Bill 414 and Senate Bill 247 were incorporated in the House and Senate indigent care committee bills, the sovereign immunity provision was not included. However, Senate Bill 251 by Senator Bob Johnson, R-Sarasota, did embrace the concept and expanded it to include all physicians contracting with the state who treat indigents funded by state or federal programs. Even so, the Florida Legislature failed to enact protection features extending sovereign immunity to physicians who contract with county health departments.

Emergency Resolution — Voluntary Drug Testing for Physicians
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

This resolved that the physicians of Florida who have vowed to preserve life and public health, and who by education and training are role models adopt a policy of voluntary substance abuse testing, and further that the FMA Delegates to the AMA House of Delegates memoralize that body to adopt substance abuse testing as a policy to discourage and curtail the usage of harmful substances by our populace.

This resolution was referred to the Medical Director of the Impaired Physicians Program for input. Also, Resolution 16 was introduced to the AMA House of Delegates where it was referred to the Board of Trustees. Based on input from county medical societies, the intent of the resolution has not been accomplished.

Emergency Resolution — Workers' Compensation Reimbursement Schedule
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED

This resolved that the Florida Medical Association immediately investigate the circumstances concerning the delay in publication of the 1986 Florida Workers' Compensation Reimbursement Schedule and report its findings to the constituent county medical societies.

This Resolution was addressed by staff in communications with AMA legal counsel requesting the AMA to lift the liability insurance requirement for using the CPT-4. The Department of Labor and Employment Security, Office of Medical Services, was required to purchase insurance in order to utilize the CPT-4. Because of the high cost of insurance, the Office of Medical Services was unable to get the necessary funds to purchase the insurance to utilize the CPT-4. As a result of FMA negotiating with the AMA, the insurance requirement has been lifted by the AMA. A hearing was held to administer the new rule to implement the fee schedule. The Department of Insurance identified at the hearing that there were several discrepancies found in the methodology, and that several of the procedures in the data base were incorrectly calculated. Due to data discrepancies, the Department of Insurance asked that the fee schedule be withdrawn until the errors that had been identified had been corrected, as well as other unanswered questions that had been addressed. The data base has been updated by the Office of Medical Services and has been presented to the Three Member Panel for their consideration. In 1986 a 3.1 percent increase was adopted but was not allowed to go into effect because of the undue delays brought about by trying to obtain insurance to utilize the CPT-4 nomenclature as well as the Insurance Department requiring the Office of Medical Services to recalculate the data base. The FMA will continue to seek more equitable reimbursement for Workers' Compensation services and will also be seeking an increase for the 1987 year to be combined with the 1986 already approved increase.

COUNCIL ON SCIENTIFIC ACTIVITIES
Pierre J. Bouis Jr., M.D., Chairman
(Reference Committee No. I, page 1057)

HOUSE ACTION: ADOPTED

The Council on Scientific Activities has concluded another successful year including two meetings of the Committee on Medical Education, five continuing medical education accreditation surveys, and continued excellence in medical journalism exemplified by *The Journal of the Florida Medical Association, Inc.* The Committee on Medical Education met on January 23, 1987, and May 15, 1987, in Tampa. The Council's work is summarized under the heading of each major activity.

Committee on Medical Education

Orris O. Rollie, M.D., Orlando, has completed another active year as Chairman of the Committee on Medical Education. Major activities of the Committee have centered on the 113th Annual Meeting Scientific Program, FMA accreditation of continuing medical education sponsors, and new FMA mandatory CME requirements which coincide with requirements for medical relicensure. A major event of the year was an on-site evaluation of FMA accreditation policies and procedures conducted by representatives of the Recognition and Review Committee of the Accreditation Council for Continuing Medical Education (ACCME).

Annual Meeting Scientific Program

The Committee has coordinated a scientific program of the highest educational value for the 113th Annual Meeting in collaboration with FMA recognized specialty groups. Some twenty-five specialty groups have planned scientific sections and socio-economic programs. In addition to scientific and socio-economic programs, the FMA will offer its Risk Management Seminar which satisfies the five-hour state-mandated requirement for relicensure. A total of seventy-one exhibit spaces will be filled with technical, commercial, educational and scientific exhibits. As has become a tradition, the Annual Meeting Scientific Program will offer a total of 15 hours of AMA Category I credit through joint sponsorship of the Florida

Medical Foundation Committee on Continuing Medical Education. Additional joint sponsorship by the University of South Florida College of Medicine, the University of Florida College of Medicine and the University of Miami School of Medicine will be included.

Leadership Conference

The Committee on Medical Education sponsored the Second Annual Workshop for CME Sponsors at the 1987 Leadership Conference. Featured speaker was Howard S. Madigan, M.D., Chairman, Accreditation Council for Continuing Medical Education (ACCME). Topics included "The CME Landscape", "Survival Kit for CME in the Community Hospital", "Needs Assessment and Evaluation: A Georgia Perspective", "The When and Where of CME: Hotel Selection", "Preparing Effective Audio-Visuals", and "The ACCME and the Committee for Review and Recognition". Over forty-five CME planners attended and rated the program as excellent. This workshop has become an important ingredient of the Leadership Conference.

Accreditation

Since the last Annual Meeting, the following accreditation actions have been taken:

- American Heart Association, Suncoast Chapter, Reaccredited for a four-year period effective August 19, 1986, to August 18, 1990
- Holmes Regional Medical Center, Provisionally Accredited for a two-year period effective May 22, 1987, to May 21, 1989
- Parkway Regional Medical Center, Reaccredited for a four-year period effective December 17, 1986, to December 16, 1990
- University Community Hospital, Reaccredited for a one-year period effective April 8, 1987 to April 7, 1988
- Winter Haven Hospital, Reaccredited for a one-year period effective October 13, 1986 to October 12, 1987

Committee on Scientific Publications

R.G. Lacsamana, M.D., has completed his second year as Editor of *The Journal of the Florida Medical Association, Inc.*, and Chairman, Committee on Scientific Publications. The JFMA has maintained its high level of excellence in medical journalism and is one of the foremost state medical association publications. This Association year included four special issues: Special Issue on Indigent Care, Jacques Caldwell, M.D., Guest Editor, February; Historical Issue on Medical Education in Florida, H. Frank Farmer, M.D., Ph.D., Historical Editor, July; Special Issue on Medical Ethics, Pierre J. Bouis Jr., M.D., and David H. Smith, Ph.D., Guest Editors, August; and Special Issue on Carotid Artery Surgery, Daniel B. Nunn, M.D., Guest Editor, September.

COUNCIL ON SPECIALTY MEDICINE

Thomas D. Bartley, M.D., Chairman

(Reference Committee No. I, page 1057)

HOUSE ACTION: ADOPTED

The Council on Specialty Medicine held two meetings during the 1986-87 Association year: January 17, 1987, and May 30, 1987. Three major recommendations were approved by the Council and submitted to the Board of Governors.

At its initial meeting in January, FMA President James B. Perry, M.D. outlined a concept entitled "relative value of medical mishaps or damages". Dr. Perry called on the Council to assist the FMA in having each specialty group develop for every single possible untoward event the relative value of damages. Dr. Perry warned that if organized medicine does not undertake this type of an approach to the assessment of damages, a governmental agency will ultimately do it. The Council responded that it would consider the feasibility of such an undertaking once the details of the proposed relative value approach were presented to it. Dr. Perry also asked the Council to develop a relative value of indigent care. In other words, what are the charges on a relative basis that physicians would be will-

ing to receive for the provision of care to indigents. The Council responded that it would also like to consider this approach, but would need to see the details in writing.

At its second meeting in May, the Council expressed its concerns about encroachments on the practice of medicine. Accordingly, Dr. Bartley established two ad hoc committees: (1) Ad Hoc Committee on Prescribing Encroachment; and (2) Ad Hoc Committee on Encroachments on Medical Practice. The Council further heard a presentation by the Administrator of the Office of Technical Assistance of the Hospital Cost Containment Board (HCCB), who discussed a survey which the HCCB sent to over 11,000 physicians in June 1987, to obtain physician charge data by specialty for certain procedures as detailed on the survey. The Council emphasized that it wished to be involved in the interpretation of the data collected by the HCCB.

With regard to the important function of specialty group recognition, the Council recommended that continuing recognition be approved for the Florida Academy of Family Physicians and the Florida Region, American College of Surgeons. In response to a recommendation approved by the House of Delegates at the 1986 Annual Meeting, the Council developed criteria for probation and procedures for termination for approval by the Board of Governors. The Council further recommended that the Florida Association of Nuclear Physicians and the Florida State Surgical Division, International College of Surgeons, be terminated from the specialty group recognition program for failure to apply for recognition after being on probation and continued lack of involvement with the Council. Regarding the remaining 16 specialty groups due for recognition, ten submitted their applications for continuing recognition by the deadline of May 31, 1987. For the six specialty groups which did not submit their applications by the deadline, the Council approved an extension of the deadline to June 30, 1987. Special group applications due for the current 1986-87 FMA year will be processed during the summer and submitted to the House of Delegates in a supplemental report.

SUPPLEMENTAL REPORT OF THE COUNCIL ON SPECIALTY MEDICINE
(Reference Committee No. I, page 1057)

HOUSE ACTION: ADOPTED AS AMENDED

The Council on Specialty Medicine by unanimous vote approved the following recommendation on August 28, 1987.

RECOMMENDATION NO. 1

Specialty Recognition: That the House of Delegates approve continuing recognition of the following specialty groups who have met the criteria established by the FMA House of Delegates for recognition by this Association:

Florida Society of Anesthesiologists
Florida Society of Clinical Oncologists
Florida Society of Dermatology
Florida Endocrine Society
Florida Gastroenterologic Society
Florida Association of General Surgeons
Florida Society of Neurology
Florida Orthopedic Society
Florida Society of Pathologists
Florida Chapter, American Academy of Pediatrics and the Florida Pediatric Society
Florida Society of Plastic and Reconstructive Surgeons
Florida Society of Rheumatology
Florida Society of Thoracic and Cardiovascular Surgeons
Florida Urological Society

The Council granted an extension to submit applications for continuing recognition to the Florida Society of Neonatal-Perinatologists and the Florida Society of Physical Medicine and Rehabilitation. If the applications of these two specialty groups are not received prior to the next meeting of the Council, in time for processing and consideration, then the Council will vote on their recognition status and whether they should be placed on probation.

COUNCIL ON MEDICAL SERVICES

Joseph T. Ostroski, M.D., Chairman
(Reference Committee No. II, page 1059)

HOUSE ACTION: ADOPTED

The Council on Medical Services, after fashioning approximately 65 recommendations on a wide range of subjects for the Executive Committee and Board of Governors, is completing another active year.

The Council met three times since the 1986 Annual Meeting to receive and act on reports of component committees and to study other matters referred to it. Meetings, all in Tampa, were conducted on October 3, 1986; on January 18, 1987; and May 22, 1987.

Inasmuch as the Council's major activities will be reflected in Report B of the Board of Governors, this report will present in summary fashion an overview of the various matters that have occupied the Council and its component committees over the past several months.

A new Ad Hoc Committee on Correctional Medical Care was formed within the FMA this past spring. Chaired by James T. Howell, M.D., of West Palm Beach, this Committee was placed under the jurisdiction of the Council on Medical Services. Formation of this Committee grew out of a communication from A. G. Condon, Jr., Chairman of the State of Florida's Correctional Medical Authority (CMA).

In order to complete various statutory charges pertaining to health care delivery in Florida's correctional system, Mr. Condon asked the FMA if it could establish an ad hoc committee to work with the CMA. Thus, Dr. Howell's Committee has a dual role involving both the State of Florida through the CMA and the FMA.

Initial problems to be considered by the new Committee include: (1) proposals to upgrade services at the Reception Medical Center at Lake Butler; (2) qualifications of prison physicians; (3) physician prescribing practices for inmates; (4) development of a comprehensive plan for AIDS education for all correctional officers, health care personnel and inmates; and (5) strategies for both internal and external review of quality of care.

The Committee on Substance Abuse, chaired by Joseph H. Deatsch, M.D., of Jacksonville, has had a busy agenda each time it has met. Before autumn, the Committee hopes to have in the hands of Florida physicians its new cocaine handbook, which is designed to help physicians identify cocaine addicts in their practice more readily. The Committee also hopes to offer, for the first time this fall, a new continuing medical education curriculum designed to refresh physicians' knowledge, in the context of modern developments, of sound prescribing practices as they pertain to controlled substances. This course is being developed in cooperation with the American Medical Association and the University of South Florida College of Medicine.

Also on the Committee's agenda, is a possible application to the National Institute on Drug Abuse for a physician education grant. The Committee envisions use of teleconferencing to bring to primary care physicians, in particular, the knowledge necessary to identify chemical addiction among their patients.

The Committee on Substance Abuse will be playing an important role in the National Invitational Conference on Prescription Drug Abuse, which will be held in Florida with FMA co-sponsorship early in 1988.

The Committee on Aging, headed by Eric A. Pfeiffer, M.D., continued to participate in programs and monitor developments concerning Florida's older population. In cooperation with the FMA Department of Communications, the monthly column entitled "Health Notes for Older Adults" continues to be sent to Florida newspapers.

Linda A. Marraccini, M.D., of Miami, has posted a most impressive record in her first year as Chairman of the FMA Committee on School Health. The Committee continues to be concerned about the State of Florida's policy of accepting school student examinations conducted by chiropractors. In this connection, the Committee had developed a number of approaches to encourage more M.D.'s and D.O.'s to volunteer their services for school entry and athletic physicials thus reducing, and perhaps even eliminating, the reliance on chiropractors and other limited care practitioners for these examinations.

The Committee on School Health has reviewed the 1987 School Health Nursing Feasibility Study that was ordered by the 1986 Legislature and has made appropriate recommendations to the Board of Governors.

A representative of the Committee played an active role in the development of the 1987 Florida Conference on School Health, which was conducted in Tampa, April 29 to May 1; and Joseph T. Ostroski, M.D., Chairman of the Council on Medical Services, was appointed by the Board of Governors to serve as a member of the Florida Foundation for School Health, a primary sponsor of the biennial conference.

Once again, the attention of the Committee on Emergency Medical Services, ably led by H. Quillian Jones Jr., M.D., of Fort Myers, was focused on establishment of a truly effective trauma care system in Florida. This year the issue became obfuscated by the presence of a parallel issue — that of professional liability in the emergency room and trauma center setting, and as this report was prepared, it appeared that FMA's hopes for a state-of-the-art trauma system will carry over into 1988.

The Committee on Voluntary Health Agencies and Allied Health Professions concentrated this year on re-establishing relationships with Florida's major statewide voluntary health agencies through the Florida Voluntary Health Association. A representative of the Committee participated in FVHA's Annual Meeting this year, and a series of articles featuring the FVHA's member agencies (e.g., Florida Division of the American Cancer Society, Florida Affiliate of the American Heart Association, and the American Lung Association of Florida) began appearing in *FMA Today* last February. The Committee is chaired by William W. Thompson, M.D., of Fort Walton Beach.

Donald S. Kwalick, M.D., of Tampa, Chairman of the Committee on Public Health and its membership have begun making plans for a proper observance of the 100th anniversary of Florida's public health system, which began in 1889 with the establishment of the old State Board of Health.

The Acquired Immune Deficiency Syndrome (AIDS) crisis continues to be a matter of major interest to the Committee on Public Health, which has analyzed several bills of the Legislature and has taken actions on other matters as appropriate. Among other things, the Committee has urged that the FMA work to end the discrimination that many AIDS patients apparently experience when seeking treatment for chemical addiction.

SUPPLEMENTAL REPORT
COUNCIL ON MEDICAL SERVICES
(Reference Committee No. II, page 1059)

HOUSE ACTION: ADOPTED

This supplemental report updates the report of the Council on Medical Services in order to include the meeting of the Committee on School Health, held in Tampa on June 28, 1987. This meeting was chaired by Linda A. Marraccini, M.D., Chairman, Committee on School Health.

The Committee on School Health heard a presentation on school health services from Donald S. Kwalick, M.D., M.P.H., Chairman, Committee on Public Health. As a result, the Committee acknowledged a need for flexibility in school health services by school district and locality. The Committee recommended that the FMA strongly support increased funding for county public health unit services for adolescent health care.

A great deal of the Committee's focus was on Acquired Immune Deficiency Syndrome (AIDS). The Department of Education (DOE) representatives at the meeting informed that DOE has applied for an AIDS education grant from the U.S. Centers for Disease Control for public school education. DOE also plans to conduct a statewide workshop on AIDS in October with representatives from each school district in the state. The Committee further received news from staff that the AMA has contacted the FMA about a grant from the Centers for Disease Control that the AMA has applied for. The grant in the amount of $100,000 will create a program designed to train physicians to speak authoritatively and accurately about AIDS to secondary schools and other community groups.

The Committee reviewed correspondence from the American Medical Women's Association, which encouraged state medical societies to contact their state boards of education to include the dangers of smoking in school health curricula. The Committee endorsed this position and added smokeless tobac-

co as a substance that should also be the subject of school curricula on hazards to health. The Committee recommended that the FMA strongly urge the appropriate state agency to publish and distribute anti-smoking and anti-smokeless tobacco brochures; and that the FMA recommend that school boards consider establishing "quit smoking" and "quit using smokeless tobacco" clinics for students, teachers, administrators, coaches, and related personnel in the school system.

The Committee received a report that the Florida School Health Association has gone on record expressing the need for increased funding for school health services. The Committee endorsed that position. In a related report, the Department of Health and Rehabilitative Services (HRS) stated that no additional services were funded by the 1987 session of the Florida Legislature for School Health Services. However, the legislature did appropriate funds for the College of Public Health, University of South Florida, to undertake a needs assessment study of health services in schools.

This meeting of the Committee on School Health was attended by members of the Committee, as well as by regularly attending representatives of DOE, HRS, Florida School Health Association, Florida Association of District School Superintendents, Florida Osteopathic Medical Society, and Florida Dental Association. The next meeting of the Committee was tentatively scheduled for October, 1987.

SUPPLEMENTAL REPORT II — COUNCIL ON MEDICAL SERVICES
(Reference Committee No. II, page 1059)

HOUSE ACTION: ADOPTED

This supplemental report updates the report of the Council on Medical Services in order to include the August 11, 1987 meeting of the Ad Hoc Committee on AIDS. This meeting was chaired by Daniel L. Seckinger Jr., M.D., Chairman, Ad Hoc Committee on AIDS.

The Ad Hoc Committee on AIDS was formed by the FMA subsequent to action by the Board of Governors at its June, 1987 meeting. The Board of Governors established the Ad Hoc Committee in order to enable the FMA to fully devote its attention to the AIDS crisis confronting Florida and the nation.

The membership of the Ad Hoc Committee on AIDS is as follows: Daniel L. Seckinger Jr., M.D., Miami, Chairman; E. Joan Barice, M.D., Singer Island; David G. Droller, M.D., Ft. Lauderdale; John C. Eustace, M.D., Miami Beach; Paul T. Harrington, M.D., Jacksonville; James T. Howell, M.D., West Palm Beach; Donald S. Kwalick, M.D., Tampa; Linda A. Marraccini, M.D., South Miami; E. Charlton Prather, M.D., Tallahassee; and Gerold L. Schiebler, M.D., Gainesville.

The consensus of the Committee was that the time has come for the FMA to take additional positions on AIDS and bring the strength of the FMA organization to bear on the crisis of AIDS, which affects in some manner all segments of society. The FMA through this Committee needs to develop action plans, to effectively combat AIDS, educate physicians and the public, and to coordinate its activities with other appropriate organizations and agencies.

The Committee developed a mission statement, which was adopted as follows:

The purpose of the Ad Hoc Committee on AIDS is to recommend policy positions and actions which the FMA should undertake with regard to AIDS based upon the best scientific knowledge and medical judgment available. Its mission in developing such policy and action recommendations is to work closely with the Governor's Task Force on AIDS, the AMA, and other appropriate federal, state and local agencies and organizations in order to increase the public's awareness and ability to prevent the incidence of AIDS and its spread among the general population. The FMA Ad Hoc Committee on AIDS accordingly will be involved in educating physicians and other health care professionals, as well as the general population, and those segments of population at greatest risk, in order to protect and promote the public's health. And further, its mission is to develop to the extent feasible agreed upon positions with respect to AIDS so that organized medicine and individual practitioners can speak in unison and authoritatively on this subject.

The Committee discussed the socio-political issues that envelop the medical and scientific aspects of AIDS. As a communicable disease that threatens the public health, there is inherent in AIDS as a matter of public policy concern about balancing the rights of the individual with the police power of the state. Such issues are: mandatory testing versus individual rights; a physician's legal requirements to report AIDS versus a patient's rights to confidentiality; the physician's professional mandate to treat all

patients who seek his or her help versus the fear of catching the disease that results in refusal and possible discrimination against the rights of a patient for treatment; the support or opposition to prosecution of AIDS patients in certain circumstances or of health care providers in certain cases; the rights of prison inmates versus the opportunity to prevent AIDS spread in prisons and later to society by released prisoners; AIDS and its impact on health insurance, such as a purported pre-existing condition causing deniability by the insurance company of responsibility for AIDS claims; anonymous reporting by laboratories and state law; the rights of school children with AIDS and those without; the responsibilties of medical records librarians and requirements which may prohibit HIV reporting from one physician to another.

The Committee expressed its need to know what are the legal obligations of physicians regarding AIDS and the legal implications of recommendations or positions of the Committee. In that regard, the Committee felt that there was a very real need to have legal council present at meetings of the Committee as it deliberates the various issues related to AIDS. The feeling was that legal guidance would be essential in order for the Committee to appropriately conduct its business.

The Committee discussed Report YY as approved by the AMA House of Delegates at the AMA Annual Meeting in June of 1987. The report, which is entitled "Prevention and Control of AIDS," is to be reviewed by the Ad Hoc Committee on AIDS and discussed at the next meeting of the Committee in terms of the specific applicability of the recommendations to the State of Florida.

The Committee reviewed policy on AIDS and school children, as originated from the Committee on School Health and entitled "Recommendations concerning immuno-compromised school children including those with acquired immune deficiency syndrome (AIDS) and AIDS Related Complex (ARC)." The basic thrust of this policy is that the situation of each child must be assessed individually by the child's physician and a physician representing the school system.

A second proposed policy of the FMA emanating from the Committee on Public Health, pertaining to a statement on AIDS and Blood Transfusions, was reviewed by the Committee.

With regard to a third proposed policy of the FMA, the Committee will develop plans for the implementation of the recommendation to accelerate professional and public education on AIDS in conjunction with the College of Public Health of the University of South Florida and other institutions.

The State Health Officer, E. Charlton Prather, M.D., reported on activities of Florida's state level public health agency. He brought attention to Florida laws pertaining to AIDS. They are: Section 381.231, Florida Statutes, pertaining to the reporting of communicable diseases; Section 381.606, Florida Statutes, pertaining to infectious diseases, declaration of threat to the public's health and confidentiality; and Sections 384.22-34, Florida Statutes, pertaining to the Control of Sexually Transmissible Disease Act, which includes Section 384.25, F.S., mandating reporting of AIDS cases by physicians, and Section 384.34, F.S., providing for penalties for failure to comply with the provisions of this act. Section 384.25, F.S., requires the reporting of ARC cases in addition to AIDS cases. However, the lack of definition and agreement over precisely what is an ARC case led HRS to leave ARC reporting out of Chapter 10D-3, Florida Administrative Code, which requires AIDS reporting. The State of Florida AIDS program was depicted as being under six general areas of responsibility. They were: (1) surveillance; (2) counseling/testing; (3) health education/risk reduction; (4) patient care; (5) special studies; and (6) services for residential clients.

James T. Howell, M.D., Chairman of the FMA Ad Hoc Committee on Correctional Medical Care, reported on that Committee's activity. The issue of AIDS testing in prison is a matter of great concern and the subject of extensive debate. Options regarding AIDS testing range from entry into prison to exit testing. Yet in the Florida prison system medical staff are not allowed to do HIV testing unless an event occurs, as in the case of assault for example.

The AMA House of Delegates approved a recommendation calling for the mandatory testing of inmates for AIDS in federal and state prisons. This issue will de dealt with by the Ad Hoc Committee on AIDS. The Ad Hoc Committee on AIDS agreed that the prison population to a certain extent represents a microcosm of considerations pertaining to AIDS policy and the rest of society. The Ad Hoc Committee on AIDS felt that the inmate population provides a tremendous opportunity for epidemiological studies of various types of the AIDS disease and perhaps how to effectively prevent its spread. Also, it was felt that the AIDS Committee needs to make a detailed recommendation on this issue at the appropriate time.

Donald S. Kwalick, M.D., Chairman, FMA Public Health Committee, discussed the problems of confidentiality and legal requirements, and the need to address the full scope of confidentiality in all of its aspects, which legal counsel may be able to provide guidance to the Committee. This need for clarification of confidentiality has implications for life insurance coverage for AIDS patients; for example what is a prexisting condition? What are physician responsibilities and requirements with regard to AIDS and life insurance companies who have covered persons contracting AIDS? In conclusion, the Committee agreed that all physicians in Florida need to be media responsive and media responsible on all AIDS issues.

Linda A. Marraccini, M.D., Chairman of the FMA Committee on School Health, discussed that Committee's recommendation on immuno-compromised school children including those with Acquired Immune Deficiency Syndrome (AIDS), as approved by the Board of Governors. The Committee on AIDS expressed its agreement with the content of the recommendation and commended the Committee on School Health for producing a technically correct and appropriate policy regarding AIDS and school children.

Dr. Marraccini reported that at the last meeting of the School Health Committee representatives of the Department of Education (DOE) informed the FMA that DOE is applying for an AIDS education grant from the Centers for Disease Control (CDC) for public school education. There will also be funds available through the state for competitive grants for statewide AIDS education.

The committee reviewed several items of interest. These included an **AMA Grant Application for Education of Physicians to Speak about AIDS in Secondary Schools and Community Organizations.** The AMA has invited the FMA to be one of six medical societies in the United States (the others are Washington State, California, Colorado, North Carolina, and Pennsylvania) to participate with the AMA in a CDC funded grant to provide AIDS training for physicians to speak about AIDS in secondary schools and to community groups. If CDC accepts the proposal from the AMA, each participating state medical society would be required to:

—Contact county medical associations and state components of medical specialty organizations. With their help, identify physicians who are appropriate and willing to be trained and to carry out a minimum of 10 hours of consulting activity in one year. Assure geographical representation of the physician pool.

—Make arrangements for physical needs for training workshops.

—Contact the public health department to learn of state activities and determine how to integrate this program into those activities.

—Contact state boards of education and the state component of national education organizations collaborating in the program. Alert them to the availability of consultants and discuss ways to utilize them.

—After training has occurred, serve as contact for schools needing help and assign an appropriate consultant.

—Review the activity of the program monthly. If there has been no activity in some geographical areas, contact local medical association in that area and ask it to contact the school superintendent in that area to develop activity.

—Follow-up all recipient-consultant meetings. Obtain a report of activities from both the recipient and consultant (AMA will provide format). Compile statistics on the number and kinds of activities and some qualitative feedback concerning the interaction.

—Arrange a session at state medical society meeting for consultants to interact and exchange information and experiences and receive updates on AIDS developments.

The FMA has written the AMA expressing the FMA's willingness to participate, citing as one of this Association's major assets as being the existence of its Ad Hoc Committee on AIDS.

The Committee reviewed The Medical Society of Virginia and the Virginia Department of Health **AIDS Manual for Virginia Physicians.** This manual in hardback notebook form was sent to the FMA from the Medical Society of Virginia. It was referred to the AIDS Ad Hoc Committee for review and recommendation as to whether the FMA should prepare in concert with HRS a similar notebook style manual, what its contents should be, and to whom it should be distributed. This is a document containing scientific and treatment information about AIDS that is a manual for physicians rather than the general public. The Committee agreed that the FMA should prepare a publication of this sort and accordingly make an appropriate recommendation to the Council on Medical Services.

The Committee reviewed a copy of a staff document entitled "What You Must Know About AIDS?"

It was referred to the Committee for updating if it felt publication of a similar document for the general public would be useful. The Committee concurred that such a document should be prepared, and that the State Health Office could be of help in updating the document for future presentation to the committee for its review and approval.

The Committee recommended that either members or advisory members be appointed to the committee from the University of Miami School of Medicine and the University of South Florida College of Medicine. The University of Florida is already represented on the Committee.

The Committee discussed the need to inform pertinent agencies in the executive and legislative branches of the existence of the FMA's Ad Hoc Committee on AIDS, with regard to its mission and expertise.

Motion was therefore approved to recommend that the President of the FMA inform the Governor, the Speaker of the House, the President of the Florida Senate, the Secretary of the Department of Health and Rehabilitative Services, and other appropriate persons, agencies, and organizations, about the FMA Ad Hoc Committee on AIDS, its mission, and expertise; and further, to offer to the Legislature and the Governor's Office the expertise and informed recommendations about legislation and executive policy in advance of bills being filed in the legislature and while state policy is being developed by the executive branch.

The consensus of the committee was that AIDS issues are so complex, diverse, and numerous that it will be necessary for the AIDS Ad Hoc Committee to meet more often than the four times a year allowed by the Bylaws for committees. It was felt that initially the committee might need to meet as least once a month in order for the FMA to bring itself up-to-speed on the AIDS issue, including the need for input at special meetings from experts of HRS, HHS, communities in the state, and other states.

The next meeting of the Ad Hoc Committee on AIDS is tentatively scheduled for late September, 1987.

PUBLIC RELATIONS

Kay K. Hanley, M.D., Public Relations Officer
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

During 1986-87, the efforts of the FMA Public Relations Program in the area of communications continue to be primarily focused on the issues concerning the professional liability crisis. Virtually every publication sent to the membership has contained the latest information on developments of the crisis. The Board of Governors continues to believe that an involved and informed membership is the key to our efforts to succeed in bringing about tort reform.

The FMA has been working very closely with the Academic Task Force on Review of the Tort and Insurance Systems. FMA President James B. Perry, M.D., and FMA Executive Vice President Donald C. Jones have testified at every meeting of the Task Force as have numerous physicians from around the state. FMA has urged Task Force members, without success, to move up their timetable for making a final report and recommendations to the Florida Legislature. The Academic Task Force is currently scheduled to make its final report on March 1, 1988.

FMA launched a major public relations program in May to initially support the tort reform proposals considered during the 1987 Florida Legislature. A broader public relations initiative will support implementation of the long-term professional liability goals including a constitutional amendment formulated by the FMA Board of Governors at its February meeting. Activities accomplished in May included:

Mailing ten letter kits to FMA members and FMA Auxiliary members. The kits consisted of an instruction sheet, five preprinted letters, a list of state legislators, a brochure outlining the PLI crisis, and a return card to FMA. The physician or Auxiliary member was requested to urge patients or friends to take kits and mail the preprinted letters, adding a postscript, to their legislators. Thus far, over 2,400 return cards have been received by FMA indicating those people have written their legislators. An average of four legislators are listed per card indicating over 9,600 letters being mailed. The Communications

Department receives several requests each day for additional kits so this number should increase substantially.

In addition to the letter kits, billboards across the state went up the first week of May. Following is a list of the cities and the number of billboards in each city: West Palm beach (Metro Market) - 4, Ft. Lauderdale (Metro Market) - 30, Miami (Metro Market) - 25, Ocala -4, Orlando (Metro Market) - 18, Jacksonville, - 20, Lakeland - 8, Winter Haven - 4, Leesburg - 4, Daytona Beach - 5, Melbourne/Cocoa/Titusville - 5, Pensacola - 8, Panama City - 3, Tallahassee - 3, Tampa/St. Pete (Metro Market) - 39 and Sarasota/Bradenton - 3.

County medical societies were also sent a half-page ad to run in their local newspapers. The ad is actually a combination of elements from the billboard and the brochure.

Physician involvement has been very encouraging. The communications staff will explore ways to further involve physicians in future communications programs.

To coincide with the PLI PR program, the FMA has also been involved with an aggressive media relations program. A joint news conference with the AMA was held in Miami March 30 to give an update of the PLI crisis. The FMA held a news conference on May 4 in Tallahassee. Dr. Perry presented an overview of the PLI crisis and talked about the ramifications of the Supreme Court ruling; St. Paul and CIGNA leaving the state; and the Gunter plan for providing insurance to physicians. Six news releases concerning various aspects of the PLI crisis have been sent to the state's news media. Dr. Perry and Mr. Jones have also participated in several media interviews and have responded to dozens of media inquiries.

The FMA and the Florida Bar held a joint news conference May 4 to announce kickoff of the Substance Abuse Communications Program. The program is targeted at parents to inform them of the medical and legal aspects of substance abuse with information on where to turn for help if they suspect their children are abusing drugs.

The program consists of three basic parts: (1) a 30-second television and a 60-second radio public service announcement (PSA); (2) a speakers bureau of over 350 physicians and 150 attorneys, and (3) an informational brochure on substance abuse.

Florida Informed Parents, Inc., a nonprofit statewide organization located in Tallahassee, is playing an important role in the program. Its members act as a "clearinghouse" for information by distributing the brochure and coordinating the speakers bureau. They are also helping to promote the speakers bureau to their many chapters and affiliated groups.

The FMA in cooperation with Reps. Alzo Reddick and Tom Woodruff conducted a series of editorial board visits with the state's leading newspapers in an effort to establish editorial support for passage of an indigent health care bill. Dr. Perry and Mr. Jones accompanied Reps. Reddick and Woodruff on visits to the *Tampa Tribune, Tallahassee Democrat, Florida Times-Union, Orlando Sentinel* and the *Fort Lauderdale News Sun-Sentinel*. T. Wallace Hahn, M.D., substituted for Dr. Perry and Mr. Jones at the *Miami Herald* editorial board visit May 6.

The following are highlights of additional FMA public relations activities which have been carried out during the 1986-87 Association year:

1. **FMA Today** continues to be published monthly. The newspaper has grown in terms of editorial content and advertising. Begun as a 16-page tabloid, *FMA Today* now regularly contains 24 to 32 pages. A readership survey is currently being evaluated to determine any changes physicians would like to see in the content or design to make *FMA Today* a better newspaper.

2. **E.T.** (Every Thursday) continues to be published weekly. It is sent to county medical society officers and executives, specialty group executive directors and officers, and members of the Board of Governors.

3. **Medical Messages** continues to be published and mailed to Florida's newspapers on a monthly basis.

4. **Health Notes for Older Adults:** This column is published monthly. In addition to newspapers, it is also sent to many retirement homes which have internal newsletters. Readership of the column is

excellent.

5. **News Releases:** Several news releases have been issued during the past year to make FMA's position on various issues known to the media in Florida.

6. **Media Inquiries:** Answering media inquiries promptly is an important function of the FMA Communications Department. Approximately 15 to 20 calls are received each month. FMA President James B. Perry, M.D., as chief spokesperson for FMA, has done an outstanding job in discussing issues with the news media. In addition, Dr. Perry and other FMA representatives have appeared on several television programs across the state and at the national level.

7. **Speakers Training:** A high priority in the coming months will be the development of effective speakers training for physicians who serve on county medical society speakers bureaus. Efforts are being made to schedule speakers training courses for members of the FMA Board of Governors and other physicians who represent the FMA and county medical societies before various public forums.

8. **Awards:** The Medical Journalism Awards, established to encourage excellence in medical reporting by both electronic and print media, was conducted again this year and awards will be presented at the Annual Meeting. The Medical Speakers and the Medical Malpractice Prevention Awards programs also were conducted.

SUPPLEMENTAL REPORT
PUBLIC RELATIONS OFFICER
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

The Florida Medical Association Board of Governors on August 15, 1987, met jointly with the officers and executives of component county medical societies and recognized specialty groups and other interested individuals to discuss the FMA's current activities regarding the professional liability crisis.

Included in these discussions was a detailed report on the internal and external communications and public relations activities related to professional liability that have been undertaken by the Association during 1987. These activities have been carried out within the current financial constraints of the Association.

FLORIDA AMA DELEGATION

Joseph C. Von Thron, M.D.
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

It has been a pleasure to serve as Chairman of your Florida AMA Delegation during the past year, ably assisted by our Vice Chairman, Charles J. Kahn, M.D.

The continued effectiveness and influence of our delegation nationally is due to the time and effort devoted freely by your delegates and alternate delegates. Appreciation must go to:

Delegates	Alternates
T. Byron Thames, M.D.	Daniel L. Seckinger, M.D.
Joseph T. Ostroski, M.D.	James B. Perry, M.D.
Charles K. Donegan, M.D.	Lee A. Fischer, M.D.
Frank C. Coleman, M.D.	Eugene G. Peek Jr., M.D.
Richard G. Connar, M.D.	Harold G. Norman, M.D.
Charles J. Kahn, M.D.	O. William Davenport, M.D.
Joseph C. Von Thron, M.D.	Charles A. Dunn, M.D.
Louis C. Murray, M.D.	Alvin E. Smith, M.D.
Kay K. Hanley, M.D.	T. Wallace Hahn, M.D.

Delegates	Alternates
Luis M. Perez, M.D.	Arthur L. Eberly, M.D.
Sanford A. Mullen, M.D.	Dick L. Van Eldik, M.D.
J. Lee Dockery, M.D.	Henry M. Yonge, M.D.

We are pleased that our caucuses have continued to include delegates from Puerto Rico, Emilio A. Arce, M.D., and Fernando J. Cabrera; delegate from Virgin Islands, Andre Galiber, M.D.; and the delegate from Guam, Dennis T. Harston, M.D.

The AMA was again faced with a year of controversial issues demanding the full attention of your delegation. As the 1987 AMA Annual Meeting occurs after the June FMA Board of Governors meeting, this report will include a summary of activities at the 1986 AMA Interim Meeting. The activities of your delegation have been regularly reported to the FMA Board of Governors and the FMA membership through various Association publications.

A. **Southeastern Delegation:** Your delegation continued to participate in Southeastern Delegation activities which include the traditional Sunday morning Breakfast Caucus and a Monday evening reception. The delegation is composed of the following states:

Alabama	Maryland
Delaware	Mississippi
District of Columbia	North Carolina
Florida	South Carolina
Georgia	Virginia
Louisiana	

B. **Resolutions:** Your delegation was highly successful in influencing the adoption of FMA introduced resolutions as they spoke eloquently during Reference Committee deliberations and presented united testimony during sessions of the House of Delegates. The following is a summary of actions taken on each FMA introduced resolution resulting from the invaluable assistance provided by your delegation.

1. **Resolution 12 - Rally in Washington**
 Drs. Murray and Hahn sought adoption of Resolution 12 which proposed a mass rally in Washington, D.C., in 1987 to influence passage of national tort reform legislation. Unfortunately, this resolution was not adopted by the Reference Committee or the House of Delegates.

2. **Resolution 13 - PRO Program**
 Drs. Van Eldik and Smith addressed Reference Committee G on Resolution 13 which seeks to resolve quality problems encountered with the PRO. The resolution was referred to the Board of Trustees by the Reference Committee, and the House of Delegates asked for action from the Board.

3. **Resolution 14 - Health Insurance Requirement**
 Drs. Seckinger and Dunn supported Resolution 14 in Reference Committee D which called for a requirement that employers offer a fee-for-service payment option for health care coverage. A substitute Report XX and Resolution 79 on the same subject were adopted by the Reference Committee and the House of Delegates.

4. **Resolution 15 - Generic Substitution**
 Drs. Ostroski and Peek supported the adoption of Resolution 15 in Reference Committee E which required proper labeling of nontherapeutic equivalents. The Reference Committee referred the resolution to the Board of Trustees with a report back to the House of Delegates. The House of Delegates adopted the Reference Committee recommendations.

5. **Resolution 16 - Voluntary Drug Testing for Physicians**
 Drs. Thames, Norman and Perry each spoke in favor of Resolution 16 in Reference Committee H. Following a lengthy debate and strong support by our representatives, the resolution was referred to the Board of Trustees by the Reference Committee and the House of Delegates.

6. **Resolution 17 - Sample Medications**
 Drs. Murray and Hahn addressed Reference Committee B on Resolution 17 which called for opposition to federal legislation that would in any way limit the use of sample medications by physicians. A substitute Resolution 17 was adopted by the Reference Committee which addressed the

issue of sample medications included in Resolution 17, 202 and 108. The House of Delegates adopted substitute Resolution 17.

7. **Resolution 18 - Capitation as a Payment Mechanism for Medicare**
Drs. Eberly and Fischer appeared before Reference Committee A in support of Resolution 18 which addressed the subject of the expansion of federal capitation programs and asked for a thorough evaluation of such programs before any expansion occurs. The Reference Committee recommended that Resolution 18 be referred to the Board of Trustees for a report back to the House of Delegates. The House of Delegates adopted the Reference Committee recommendation.

8. **Resolution 19 - Competition in Medicine**
Drs. Van Eldik and Smith supported the adoption of Resolution 19 in Reference Committee G which proposed that the American Medical Association serve as a clearinghouse for information on the various forms of health care systems. The Reference Committee adopted a similar substitute Report NN which was adopted by the House of Delegates.

9. **Resolution 140 - PRO Regulations**
Drs. Van Eldik and Smith supported adoption of Resolution 140 in Reference Committee G which objected to the negative content of denial letters and the issue of due process. The Reference Committee adopted Report L of the Council on Medical Services in lieu of similar Resolutions 41, 76, 137 and 140. The House of Delegates, after testimony delivered from the floor, extracted Resolution 140 and adopted it along with Report L.

C. **Resolution - National Awareness Campaign**
The Southeastern Delegation, after hearing Dr. Ed Annis' spontaneous oratory, introduced the following resolution relative to Dr. Annis' unique persuasive speaking ability and his value in conveying medicine's position to the American public:

WHEREAS, the House of Delegates of the American Medical Association did approve Board of Trustees Report PP on December 9, 1986, regarding a national awareness campaign aimed at informing the profession and the public of AMA's scientific and socioeconomic activities; and

WHEREAS, Board of Trustees Report PP states that in 1987 plans call for visits to 70 cities by AMA officers, trustees and key members to make appearances on behalf of the AMA; and

WHEREAS, A national program of public speaking is an effective way to reach community groups at the local, state and specialty level, the AMA has created a new publication containing detailed advice on how to structure a speaker's bureau; and

WHEREAS, there are a number of past presidents in the House of Delegates and members of the House of Delegates who have successfully informed and motivated the public to support the aims and objectives of American medicine; therefore be it

RESOLVED, that the American Medical Association should, at once, utilize one of our most effective speakers as frequently as possible: Edward R. Annis, M.D., President of the AMA 1963-64. Dr. Annis is a competent and knowledgeable speaker; he is willing and able to speak for medicine anytime and anywhere; he is well aware of mutual problems that concern medicine and the population; he is competent to represent the House of Medicine in any forum and at the same time he can competently assure the populace that the purpose of the AMA is to assure all of quality, readily available medical care; therefore be it further

RESOLVED, that the Executive Committee and the Board of Trustees of the AMA be requested by the Southeastern Delegation to utilize the services of this eminently qualified physician as an advocate of concerned physicians whenever possible.

D. **1986 Interim Meeting**

1. **MD — DRG — Medicare Reimbursement**
The government's plan to roll physician reimbursement into Medicare payments to hospitals is being vigorously opposed by the AMA. The House adopted a resolution that adequate and appropriate resources of the Federation of American Medicine be mobilized forthwith to impress upon the Presi-

dent and the Congress the danger this proposal represents and the threat it poses to the American people. While members of the House began contacting their Congressmen and Senators to express opposition to the proposal, the AMA issued the following statement:

> "The proposal is unrealistic, unreasonable, unwise and unhealthy for our senior citizens and other beneficiaries of the Medicare program. Merely saying that such a system would be almost impossible to administer, or that the proposal is premature, since Congress has already mandated a study of physician systems under Medicare, only addresses the fringes of OMB's proposal. The real point of this is that the proposal represents just one more step on the road to rationing of care for Medicare beneficiaries. We simply don't think that's acceptable; and we believe that Medicare beneficiaries will join us in resisting these proposals ultimately aimed at rationing medical care."

2. **Peer Review Organizations**
The House of Delegates considered a comprehensive report and a number of resolutions on the many problems physicians are having with the federal government's peer review program (PRO): The House adopted the report from the Council on Medical Service which:

- described current directions in the PRO program and recent legislative mandates having an impact on PRO contained in COBRA and OBRA.

- discussed issues raised by the operation of the Super PRO and imposition of sanctions by PROs and the authority for PROs to deny payment on the basis of quality.

The report recommends that:

- the AMA develop draft federal legislation providing that a PRO shall not notify a beneficiary of a PRO determination that the quality of services provided does not meet professional recognized standards of health care until the physician has:

 1. Obtained a PRO reconsideration of the determination.
 2. Exhausted rights to judicial review of any adverse reconsideration decisions.

In adopting the report, the delegates stressed the need for immediate action concerning the issue of beneficiary notification of quality denials. The House also referred a resolution for action calling on the AMA to:

- communicate with the Department of Health and Human Services the AMA's desire to seek greater PRO discretion in the determination and handling of sanction recommendations.

- undertake legal action, as appropriate, to assure that physicians are accorded due process appeal rights in the course of PRO sanction and appeal processes.

- urge that reconsiderations and appeals of PRO actions be heard before panels of physicians in active practice.

The House adopted another resolution that asked the AMA to:

- enlist the aid of Medicare patients by encouraging them to voice any valid concerns with the PRO program to their elected federal officials.

- encourage individual physicians to facilitate such complaints to the AMA.

3. **New AMA Strategic Plan**
In a major effort to strengthen public and professional confidence in the AMA, the delegates adopted a new strategic plan for the Association. The plan contains a new key objective for the Association and two strategies to provide the AMA with an effective approach to meet future challenges.

As adopted by the House:

> "The key objective of the American Medical Association is to contribute to the professional and personal development of member physicians and to the betterment of the health of the public by developing and distributing information; by advocating health-related rights, respon-

sibilities, and issues; and by representing the profession as a whole where the image, expertise, and national scope of the AMA prove useful. This is to be done in a manner that is cost-effective, protects physician autonomy and self-determination, improves the practice of medicine, and builds public confidence in the competence and reliability of physicians.''

The two strategies are:

- Strategy One: Strengthen the Association's visibility among the profession and the public while enhancing its reputation for competence, objectivity, and commitment to excellence.

- Strategy Two: Shift the development of Association products and services from a product-driven to a market-driven approach based on an accurate determination of physician and public needs as well as a realistic appraisal of the likelihood for a positive return on the Association's investment.

COMMITTEE ON MEMBERSHIP DEVELOPMENT

Richard J. Bagby, M.D., Chairman
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Membership development is an activity of paramount importance with two basic thrusts: (1) the **recruitment** of new members for county medical societies, the Florida Medical Association and the American Medical Association; and (2) the **retention** of existing members.

With regard to recruitment, the FMA Committee on Membership Development assumes a role in partnership with the county medical societies. Retention should be a joint endeavor involving virtually all FMA committees and councils, as well as the Board of Governors and the House of Delegates. Effective retention efforts demand the orderly development and implementation of programs, policies and activities that in some direct or indirect way work to the benefit of FMA members and the patients they serve; and assuring that information about them are communicated clearly and effectively to the membership through various means.

The Committee on Membership Development is completing its most active year since it was established five years ago. In discharging its responsibilities, the Committee met three times during the year — in Tampa on November 15, 1986; February 20, 1987; and May 1, 1987. Its more important activities are summarized below:

1. **Mailings:** Direct mail is the principal vehicle for new member recruitment. Since the last Annual Meeting, several direct mailings have been dispatched. On October 10, 1986, a recruitment package that included a letter from FMA President James B. Perry, M.D., was sent to 1,280 medical students enrolled at Florida's three medical schools. In December, a similar package went to 2,487 resident physicians in Florida.

Nonmembers of FMA who had been receiving *FMA Today,* free of charge, found a membership solicitation letter enclosed with their September issue. In May, we mailed to the three hundred thirty-five 1987 medical school graduates throughout the country who will begin residency training in Florida this year as a result of the national matching program.

Also this year, the FMA participated for the fourth consecutive year in the AMA's ''Invitation to Join'' program, a mailing focusing on those Florida physicians and resident physicians who are not members of either the FMA or the AMA.

In addition, in the autumn of 1986, we launched a program in cooperation with certain county medical societies aimed at making early contact with new physicians in those counties who have recently arrived from other states. Names and addresses are taken from the weekly physician movement report published by the AMA. These physicians are sent a letter of welcome from the President of the FMA, a county medical society application, an FMA archives form and other materials. Participating counties are Alachua, Brevard, Broward, Charlotte, Citrus, DeSoto-Hardee-Glades, Duval, Escambia, Hillsborough, Osceola, Palm Beach, Panhandle, Pasco, Seminole and Walton.

2. **Special FMA Sections:** The Committee has been keeping in close touch with the new **Medical Student Section** of the FMA created by the House of Delegates at the 1986 Annual Meeting which is now organized and operating. The Committee plans to continue to assist the Medical Student Section (MSS) in its membership development efforts.

As of late April, student membership in the FMA and the MSS stood at 157, almost a fourfold increase since January of 1986, and more student applications are in the pipeline. This spring, the Capital Medical Society agreed to admit students who are enrolled in the Tallahassee-based Program in Medical Sciences (PIMS), (in which about 30 students each year take the initial year of their medical education before joining the second-year class at the University of Florida in Gainesville). We are informed that virtually all of the students in the PIMS program have applied for membership.

The Committee has developed and forwarded a recommendation to the FMA Board of Governors that would provide financial assistance to county medical societies that have student members. This particularly affects the Hillsborough County Medical Association and the Alachua County Medical Society, both of which bill active members for the cost of dinners arranged in connection with county medical society meetings. Those counties have been reluctant to recruit students because of the added expense of providing dinners.

As a result of a recommendation to the Board of Governors that originated with this Committee, a **Young Physicians Section Steering Committee** has been mobilized under the leadership of Richard G. Spurlock, M.D., of Tampa. The Committee has worked this spring on bylaws and procedures that would be implemented should the House of Delegates act favorably on a recommendation that the FMA create a Young Physicians Section.

The **Resident Physicians Section** has not been organized, but efforts will be focused on that project during the summer of 1987.

3. **Membership Development Workshop:** On November 21, the AMA and the FMA Committee on Membership Development will sponsor a Workshop on Membership Development for County Medical Societies and FMA-Recognized Specialty Groups. Speakers will include representatives of the Committee and of the AMA Department of Membership Development. The program will be a sequel to a highly successful development workshop presented in August of 1986.

4. **Enhancement of Leadership Skills Seminar for Women Physicians:** The Committee sponsored the Third Annual Enhancement of Leadership Skills Seminar for Women Physicians, a day-long program presented as part of the 1987 FMA Leadership Conference. Despite an outstanding program arranged by conference Co-Chairs Linda A. Marraccini, M.D., and medical student Jane A. Daniel, both of Miami, attendance was disappointing. For the past two years participation by women physicians as members and leaders in organized medicine has been encouraged and these efforts seem to have had a positive impact.

5. **FMA Resolutions:** The Committee conducted careful studies during the year of FMA Resolutions 86A-3 (Unified Membership with the American Medical Association) and 86A-6 (FMA Membership as a Requirement for State Licensure) and made appropriate recommendations to the Board of Governors. After reviewing materials supplied by the AMA and four "unified" states, and conducting a survey of FMA county medical societies, the Committee concluded that mandating AMA membership for all FMA members would not be advisable at this time. However, the Committee recommended that all FMA members be strongly encouraged to maintain AMA membership on a voluntary basis. With respect to Resolution 86A-6, the Committee ascertained that no state at the present time requires membership in the state medical association as a condition of medical licensure. It is believed that such an integrated system, if enacted, would inevitably invite state government interference or domination of the FMA.

6. **County Medical Society Application Procedure:** The AMA believes that some potential members may be discouraged from joining because of complex and lengthy application procedures. Accordingly, the Committee has asked the Conference of Florida Medical Society Executives (CFMSE) to review county medical society applications and application procedures to determine if it is possible to develop a simplified application form that might be acceptable to all county medical societies. The CFMSE also is looking into other aspects including the need for pictures and letters of reference to accompany applications, the length of provisional membership and related matters.

7. **Communication with the Membership:** The Committee believes that the newspaper *FMA To-*

day, which soon will celebrate its second anniversary, is an excellent publication that has served as a valuable informational tool for the membership. However, one occasionally hears physicians criticize the FMA. Often this criticism is rooted in misinformation or lack of information. The Committee has suggested to the Board of Governors that the FMA prepare a monthly column reporting on its activities for publication in the various county medical society bulletins. Hopefully, this would give FMA programs broader visibility within the membership.

8. **AMA Members / FMA Nonmembers:** The Committee is concerned about the large group of Florida physicians who maintain membership in the AMA but are not members of the FMA. As of last January, there were about 2,700 in this category. The Committee has asked the Board of Governors for authorization to survey these physicians to determine their reasons for not affiliating with their state association and county medical society.

MEDICAL STUDENT SECTION

Peter W. Lackman, Chairperson
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

In a period of less than one year since it was created at the FMA Annual Meeting in 1986, the FMA Medical Student Section has been organized and has become completely operational.

In December of 1986, a small group of students, representing all three medical schools in Florida and led by retiring student Board of Governors member Jane A. Daniel, met in Tampa and began writing bylaws to guide the fledgling Medical Student Section (MSS). These were put into final form in time to be submitted at the January 1987 meeting of the FMA Board, which approved them.

The first statewide meeting of the MSS was arranged for February 28 on the campus of the University of South Florida College of Medicine. Educational in focus, the program included excellent presentations on risk management and the techniques of legislative lobbying by FMA staff experts in those fields.

In the weeks immediately following the first statewide meeting, the three campus chapters at the University of South Florida, the University of Florida and the University of Miami busied themselves with developing "operational procedures" as required in the MSS Bylaws and electing students to represent them on the policy-making Governing Council.

The Bylaws provide that the business affairs of the MSS be supervised and carried out by a Governing Council consisting of three "student representatives" from each campus, or a total of nine members. In addition, each campus chapter elects one "alternate student representative" who participates as a voting member in the absence of one of the primary representatives from his school. The Bylaws further provide that the nine-member Governing Council elect officers from among its own membership.

The historic first meeting of the MSS Governing Council was called to order by Ms. Daniel, the temporary Chairperson, in the FMA Office in Tampa on April 25. All nine student representatives, plus two of the three alternates and other medical student leaders were in attendance.

The Governing Council elected the following officers: Peter W. Lackman, University of South Florida, Chairperson; Marc Apple, University of Miami, Vice Chairperson; Nydia J. Batty, University of Florida, Secretary-Treasurer; Christopher J. Centeno, University of South Florida, Delegate to the Florida Medical Association House of Delegates; and Robert Blais, University of Miami, Alternate Delegate to the FMA. In addition, the Governing Council nominated a highly qualified University of Florida Medical Student to the FMA President-Elect for the possible appointment to the FMA Board of Governors to succeed Ms. Daniel.

At its first meeting, the Governing Council also developed a recommendation to the Board of Governors suggesting a restructuring of medical student dues and a reduced-rate four-year membership plan for first-year medical students.

The MSS will nominate each year qualified student members for appointment to various FMA com-

mittees. In addition, the MSS will have committees of its own, including committees on legislation, membership and student benefits, and newsletter.

It should be observed at this point that as future medical practitioners, MSS members are keenly interested in legislation that affects the practice of medicine and the quality of care rendered to patients. The MSS has encouraged medical students to travel to Tallahassee this spring to observe the Legislature up close. Of course, our activities in this sensitive field of legislation will be closely coordinated with the FMA legislative program.

Another issue of some concern to the MSS is its lack of direct access to the American Medical Association Medical Student Section. Delegates to the AMA-MSS are elected locally by medical students at each school and, therefore, are not directly responsible to the state governing councils. The FMA-MSS Governing Council has asked the student AMA delegates from Florida to explore with the AMA-MSS the possibility of assigning an additional delegate to those states who have organized state medical student sections. The additional delegate would then be elected by the state group.

Finally, the FMA-MSS gratefully acknowledges the support and confidence placed in us by the leadership, the House of Delegates and the active members of the FMA. MSS welcomes this opportunity to participate and contribute to organized medicine in Florida. In carrying out its activities and work, the MSS pledges to act in what it considers to be the best interest of the FMA and in a manner befitting organized medicine.

STEERING COMMITTEE FOR THE PROPOSED FMA YOUNG PHYSICIANS SECTION

Richard G. Spurlock, M.D.

(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

The Steering Committee for the Proposed Young Physicians Section of the Florida Medical Association was established last January by the Board of Governors upon the recommendation of the Committee on Membership Development.

FMA President James B Perry, M.D., appointed six young physicians to this Committee to represent each of the four medical districts, the state at large, and the Committee on Membership Development.

The Committee met in Tampa on April 4, 1987, and had a subsequent telephone conference on May 20 to make final its recommendations to the Board of Governors and the House of Delegates.

Recommendations forwarded to the Board of Governors at its June 1987 meeting included proposed amendments to the FMA Bylaws to create the Young Physicians Section on a basis similar to the previously established Medical Student Section and Resident Physician Section. The Committee also submitted to the Board for approval a set of proposed bylaws to govern the activities of the Section.

It is hoped that the House of Delegates will vote to establish this Section which is designed to address the special needs of young physicians and to provide them with a direct link to the Board of Governors and House of Delegates. An anticipated by-product of this new component organization would be a higher rate of membership in organized medicine within the young physician group.

The AMA defines "young physician" as one who is under 40 years of age (resident and fellows excluded) or one who may be over 40 but in practice for less than five years following graduate training.

AMA statistics generated early this year revealed that there are 6,301 young physicians in Florida. It is a matter of some interest that one-third of these are not members of either the AMA or the FMA. Only one-fourth are members of both organizations.

Thus, it is clear that organized medicine has work to do with this group and the Young Physicians Section is seen as a proper channel for these efforts.

Contingent on House approval, the Committee proposes to have the first statewide business meeting of the Section next March in conjunction with the FMA Leadership Conference. Officers would be elected at that time. In the interim, the Steering Committee would continue its work in developing the Section.

The AMA's Young Physicians Section met for the first time in December, 1986, in Las Vegas, Nev., and the FMA sent a delegate. Both a delegate and alternate delegate were to attend the second meeting of the AMA group in Chicago in June.

The Committee acknowledges the support and assistance in its efforts given by the Committee on Membership Development and particulary its Chairman, Richard J. Bagby, M.D., of Winter Park.

JUDICIAL COUNCIL

Joseph H. Davis, M.D., Chairman
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

The 1987 Annual Report of the Judicial Council will summarize the Council's activities since the September, 1986, Annual Meeting of the Florida Medical Association. The Council's duties are defined in Paragraph 8, Section 3 of the Bylaws. The Judicial Council investigates the Association's activities which pertain to medical ethics, dissensions and disputes, complaints by patients against members of the Association, and questions of membership and disciplinary action. The Council reviews and recommends charters for county medical societies. The Council also is the interpretive body for the Association Bylaws. A component county medical society is the basic unit for discipline of its members. Any member subject to such action has a right of appeal to the Judicial Council. The Council may be required to review component county medical societies in respect to the adherence to binding policies adopted by the House of Delegates of the Association.

Since the last Annual Meeting of the Association, the Council has convened on the following occasions: January 17, 1987; March 30, 1987; and June 6, 1987. The current membership of the Council is as follows: Joseph H. Davis, M.D., Chairman, Miami; O. Frank Agee, M.D., Gainesville; Robert J. Brennan, M.D., Fort Lauderdale; Maurice H. Laszlo, M.D., North Miami Beach; and Kenneth C. Kiehl, M.D., Sarasota. The Council has been staffed by Donald W. Weidner, Esquire, FMA Associate General Counsel.

The Council's Activities are summarized below:

Grievance Procedures

Last year, the Judicial Council submitted to the Board of Governors, which considered and recommended to the 1986 House of Delegates, the report which was submitted as Appendix F.I., Supplement to Report C of the Board of Governors. That report was the result of over a year's study of the Association's grievance procedures.

After review by Reference Committee III, the House of Delegates considered the report and voted to authorize the Board of Governors to make modifications, if necessary, and then to implement the new procedures. In discussions with county medical societies, only two criticisms of the proposed revised procedures were brought to the attention of the Council. The first was a feeling that some of the time frames set forth may be difficult, if not impossible, for certain county medical societies to meet. The second criticism sprang from the desire of one or more county medical societies to have more time to review complaints alleging a violation of state law or regulations. This additional time could be used in an effort to prevent complaints that were serious on the surface, but that in fact were groundless, from being forwarded to the Board of Medicine.

The Judicial Council reviewed those issues and concluded that a few county medical societies could indeed have problems with the time lines set forth in the proposed plan. The Council, therefore, recommended that the Board of Governors approve the plan, but authorized the Council to modify any of the proposed time lines for individual county medical societies. In October, 1986, the Board of Governors adopted these revised procedures.

Under the procedures now in effect, county medical societies have seven days within which to forward complaints to the Judicial Council. The Council then reviews the complaint to determine whether it alleges a violation of state law or regulations. Where the complaint does not allege a violation of state law or regulations, the Judicial Council forwards the case to the county medical society which has sixty days to complete its action.

If a complaint does allege a violation of state law or regulations, the Judicial Council refers the complaint to the county medical society for submission of further evidence within thirty days. If the county elects not to submit additional information, then the case is forwarded to the Board of Medicine. If the county does supply additional information, then the Judicial Council must review the new information and decide whether the case should be referred to the Board of Medicine.

Normally, once a case is referred to the Board of Medicine, the Judicial Council stays any further action until the Board of Medicine completes its review. When the Board of Medicine action is completed, the Judicial Council reviews the case to determine whether further FMA action is warranted.

The Council believes that with these clearly established uniform procedures for handling complaints, including uniform form letters, both patients and physicians are assured due process.

When the new procedures went into effect in January, 1987, the Judicial Council had fifty cases under review. Since January, 1987, the Council has received a total of 194 cases, 142 of which have now been reviewed and completed, leaving 102 still open.

All but two county societies are in compliance with the new procedures. The two county societies in violation are Manatee and Polk. Their refusal to comply with these procedures is in violation of their charters and this fact has been reported to the Board of Governors.

Postoperative Care by Optometrists

The Council heard from Tully Patrowicz, M.D., President of the Florida Society of Ophthalmology, regarding the issue of referrals by ophthalmologists to optometrists for the handling of postcataract surgical care. Dr. Patrowicz discussed with the Council the actions of the American Academy of Ophthalmology, as well as recent state actions in North Carolina and Maryland regarding the legality of referrals for postoperative cataract surgical care. The Council reviewed, in addition to the information provided by Dr. Patrowicz, the Optometric Practice Act and the Medical Practice Act.

It was the opinion of the Council that some aspects of postoperative cataract surgical care may be legally carried out by optometrists, while other portions would clearly be within the practice of medicine. The Council was emphatic that even though Florida law might permit optometrists to perform certain procedures, ethical concerns mandate that a physician be totally responsible for postoperative surgical care of his patients. If he does not perform such postoperative care personally, he must make arrangements before surgery for referral of a patient to another ophthalmologist or to another licensed professional. In either event, he retains an ethical and perhaps legal responsibility for that postoperative surgical care.

The Council, after extensive discussion, determined that Rule 8 of the Code of Ethics of the American Academy of Ophthalmology should be utilized as a basis for preparing a proposed rule which would be submitted by the Florida Medical Association to the Board of Medicine. Rule 8 of the American Academy of Ophthalmology provides as follows:

> "**Postoperative Care.** The providing of postoperative eye care until the patient has recovered is integral to patient management. The operating ophthalmologist should provide those aspects of postoperative eye care within the unique competence of the ophthalmologist (which does not include those permitted by law to be performed by auxiliaries). Otherwise, the operating ophthalmologist must make arrangements before surgery for referral of the patient to another ophthalmologist. The operating ophthalmologist may make different arrangements for the provision of those aspects of postoperative eye care within the unique competence of the ophthalmologist in special circumstances, such as emergencies or when no ophthalmologist is available, if the patient's welfare and rights are placed above all other considerations. Fees should reflect postoperative eye care arrangements with advance disclosure to the patient."

The Council recognizes that Florida law does not currently define what procedures may be performed

only by ophthalmologists as distinguished from other physicians or from other licensed professionals. The adoption of the principles embodied in Rule 8 by the Board of Medicine would, however, constrain the judgment of ophthalmologists to some degree in that an ophthalmologist would only be able to refer a patient for postoperative care to another professional if the ophthalmologist believes the professional to be competent and prepared to discharge the ophthalmologist's duty to the patient. Rule 8 would restrict those areas that are integral to patient management and completing the surgical/medical process, but does not govern aspects of postoperative care that are not within the unique competence of the ophthalmologist, such as minor refractions and dispensing of spectacles. The Council recommended, and the Board of Governors adopted, a resolution urging the Board of Medicine to adopt a rule embodying the principles of Rule 8.

Interpretation of FMA Bylaws for Nonlicensed Physicians

The Council considered a request from the FMA Committee on Membership Development for interpretation of the Florida Medical Association Bylaws regarding whether a county medical society must make a provision in its bylaws for nonlicensed physicians to become members of the county medical society.

The Council considered the FMA Bylaws, particularly Chapter 1, which provides that "Any doctor of medicine may be accepted into membership . . .," and further provides in Section 2, that nonlicensed doctors of medicine would be considered associate members. However, in Chapter 11 of the Bylaws dealing with component societies, Section 3 on membership, it is provided that: "since membership in a component society is a prerequisite to membership in the Florida Medical Association, every reputable and **licensed** doctor of medicine . . . shall be privileged to apply" (emphasis added). It is apparent, therefore, that there is a conflict in our Bylaws over the acceptability of allowing nonmembe- physicians into membership. The Judicial Council recently held, and the Board of Governors concurred, that component societies may have membership requirements more stringent than those of the Florida Medical Association. Therefore, it is the opinion of the Council that a county medical society is permitted to require licensure as a condition of membership. The Council further recommended, and the Board of Governors agreed, to refer this issue to the Bylaws Committee so that the Committee and the Board can ensure that the Bylaws are clear and reflect the current intent of the Association.

Referrals from the House of Delegates — Nasogastric Tubes

The Board of Governors referred Resolution 86A-2, submitted by the Sarasota County Medical Society, to the Judicial Council for a recommendation. The Judicial Council considered Resolution 86A-2 dealing with nasogastric tubes and specifically with the resolve that all life-sustaining mechanisms, including nasogastric tubes, be administered only by order and under the direction of the patient's personal physician. The Council, after discussion and careful consideration, was of the opinion that this Resolution should be adopted and recommended, and the Board of Governors adopted a resolution that nasogastric tubes should be administered only by order and under the direction of a patient's personal physician.

SUPPLEMENTAL REPORT OF THE JUDICIAL COUNCIL

(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

The Supplemental Report updates the report of the Judicial Council regarding grievance procedures.

In 1986, the House of Delegates approved, and the Board of Governors implemented, substantial changes in the Judicial Council grievance procedures. These changes came about after an in-depth study with outside experts from the Florida Bar Association and the Board of Medicine revealing that both the County Medical Societies and the FMA faced potential liability when assuming the responsibility for investigating serious complaints and then failing to do so.

Through these procedures, the Judicial Council has made an effort to:

1. perfect a uniform, consistent, equitable and timely procedure without compromising organization involvement — advocacy and protection;

2. prevent redundancy of effort or dual-role conflict of interest and guarantees by FMA;

3. expedite, without compromising the process or quality claim resolution; and

4. to not increase, and perhaps reduce, FMA and/or County Medical Society human and financial expenditures.

One additional benefit of handling all complaints at the FMA level has allowed the Judicial Council to collect data regarding complaints at a statewide level.

As of September 1, 1987, there were 148 open cases and 184 closed cases. This gives a total of 332 grievances handled or 41.5 grievances a month. Below are two tables consisting of short summaries of the complaints. It is important to note that this summary is taken from the complainant's point of view.

The open cases consist of the following complaints:

Fee	38
Misdiagnosis	28
Insurance	22
Patient Relations	21
Drug Dispensing	20
Medical Records	6
Staff	5
Sexual Misconduct	4
Not Returning Calls	2
No Call Coverage	1
Advertising	1

The closed cases consisted of the following complaints:

Fee	43
Patient Relations	39
Insurance	34
Misdiagnosis	22
Drug Dispensing	13
Expired License	8
Sexual Misconduct	7
Medical Records	6
Not Returning Calls	5
Staff	5
CMS Membership	1
Unnecessary Testing	1

Fifty cases of the total 332 reviewed by the Judicial Council through September 1, 1987, have been received from the Department of Professional Regulation. Thirty-one of the fifty cases involved dispensing of controlled substances.

The closed cases have been summarized in the following ways:

Ruling for Doctor	96	
Reached Compromise	33	
Ruling for Patient	22	
No Further Action	20	* (DPR Cases)
Complaint Dropped	10	
To Board of Medicine	2	**
CMS Withheld	1	

*Most County Medical Societies have a policy not to do anything further with a case the Board of Medicine has ruled on.

**The two cases submitted to the Board of Medicine were sent by the patients after their contact with the County Medical Society or FMA. It is the policy of the FMA not to investigate complaints the Board of Medicine is involved in investigating.

Summary of County Medical Association Grievance Files
As Of September 1, 1987

	Total Grievances Received	Average Days Opened
Alachua	5	68
Bay	1	51
Bradford	1	51
Brevard	11	159
Broward	39	50
Capital	2	81
Charlotte	7	69
Citrus	1	99
Clay	1	120
Collier	5	90
Dade	34	129
Duval	32	131
Escambia	3	200
Hendry	1	
Hernando	1	75
Highlands	1	
Hillsborough	36	67
Indian River	3	54
Lake	2	17
Lee	8	48
Manatee	3	156
Marion	6	57
Martin	1	
Okaloosa	1	
Orange	25	85
Palm Beach	28	70
Panhandle	1	263
Pasco	7	123
Pinellas	28	101
Polk	2	15
Sarasota	14	83
Seminole	4	63
St. Lucie	1	
Volusia	17	31
State Total and Average	332	91

FLORIDA MEDICAL FOUNDATION

James B. Perry, M.D., President
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

The primary purpose of the Florida Medical Foundation continues to be to foster the development of quality continuing medical education opportunities, to offer an effective treatment program for impaired physicians, and to provide a peer medical utilization review mechanism.

The Florida Medical Foundation Board of Directors has continued to hold its meetings in conjunction with meetings of the Florida Medical Association Board of Governors. Major activities of the Foundation are summarized below.

Peer Medical Utilization Review

The Committee on Peer Medical Utilization Review, chaired by Charles B. Mutter, M.D., met four times during the Association year to review charts of Florida physicians referred to the Florida Medical Foundation peer review process by the Medicare, Medicaid and Workers' Compensation insurance carriers. During the four meetings, the Committee reviewed four cases for Workers' Compensation, five cases for Medicaid, and 110 cases for Medicare. The Committee anticipates another moratorium to be implemented for Medicare review as a result of budgetary reductions placed on the peer review program by the Health Care Financing Administration.

Committee on Continuing Medical Education

The Committee, as an organization accredited by the Florida Medical Association, continues to make major contributions to continuing medical education in Florida. In 1986, the Committee, under the leadership of Robert E. Cline, M.D., Chairman, reviewed and approved 260 applications from specialty groups, hospitals and other CME providers for a total of 1,363 hours of American Medical Association Category I credit. Additionally, members of the Committee have actively served as members of site survey teams for the accreditation of hospital-based programs of continuing medical education. The activities of the Committee continue to assure physicians of Florida that educational programs offering AMA Category I credit are of the highest quality.

Physicians Recovery Network

After several years of intermittent negotiations, a contract was signed between the Foundation's Physicians Recovery Network (formerly the Impaired Physicians Program) and the Florida Department of Professional Regulation, which effectively and officially links the impaired professionals program of the public and private sectors. Under the contract, PRN and its Director, Roger A. Goetz, M.D., will administer intervention, treatment and rehabilitation programs for Florida-licensed osteopaths, podiatrists, veterinarians and pharmacists, as well as medical doctors. As of May 29, 1987, PRN has been involved in 533 cases since its beginning in 1981, making it the most used medical association sponsored program for physician impairment. Of the total, 335 cases were opened since the position of medical director became full-time early in 1985.

Medical Student Loans

The Florida Medical Foundation Medical Student Loan Program remains under a moratorium established in 1977. Eight of the nine original loans remain outstanding and are slowly being repaid. The outstanding balance on these loans is currently $19,235.03. Payments are being made regularly on three loans; three are being collected through legal channels; and two are pending litigation. The Guaranteed Medical Student Loan Program administered by the Florida National Bank Trustee has an outstanding balance of $18,798.21. The recipients are being charged interest on their respective unpaid balances at 10% per annum until the balances are repaid. Two of these loans have been paid in full this year. With the continuing attention devoted to the collection of these loans, we are optimistic the balances will be significantly reduced during the coming year.

PHYSICIANS RECOVERY NETWORK COMMITTEE
(Formerly, Committee on Impaired Physicians)

Guy T. Selander, M.D., Chairman
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

After almost six years of on-again, off-again negotiations, the Florida Medical Foundation and the Florida Department of Professional Regulation (DPR) reached agreement this year on a contract that officially

synchronizes the impaired professionals program of the two organizations.

The contract signing in April was a landmark event in a year in which the FMA/FMF Physicians Recovery Network (PRN) grew to become the most widely used state program for physician health in the country. As of May 29, PRN maintained files on more than 530 physicians and other health care providers compared with New York's 250 and New Jersey's 300.

Under the FMF-DPR contract, PRN receives $107,000 in state funds during the contract period (January 1 to December 31, 1987). In return, FMF and PRN will operate DPR's Impaired Practitioners Program to the extent that it applies to licensed physicians, osteopaths, veterinarians, pharmacists and podiatrists. In the contract language, DPR approved the assignment of PRN Medical Director Roger A. Goetz, M.D., as the consultant and medical director for the combined program.

PRN's and Dr. Goetz' responsibilities under the contract include: assisting DPR in developing criteria for approved treatment providers; conducting site visits of treatment facilities; aiding DPR in development and implementation of identification and referral program; arranging and conducting educational programs and intervention workshops; participating in intervention with impaired practitioners; and maintaining confidentiality of health care providers who are undergoing treatment.

Now that the contract is in effect, it is estimated that intake into the program will average 17 new physician cases per month and six to eight other health care providers.

Following is a summary of other major activities and events related to the FMF-PRN:

1. **Name Change:** For more than six years the program has functioned under the title of "Impaired Physicians Program." This year, your Committee suggested, and the Board of Governors agreed, that the name be changed to "Physicians Recovery Network" and "Physicians Recovery Network Committee." The rationale is that the old name fallaciously implies "once an impaired physician, always an impaired physician." This is not true. On the contrary, the once impaired physician who undergoes effective and successful treatment and who makes an excellent recovery is often in the best health ever and better able to perform his duties as a physician. Since the ultimate aim of our efforts is recovery, the new title seemed quite appropriate.

2. **Caseload:** As of May 29, 1987, PRN had interfaced with 533 physicians and other health care providers since intake began in January of 1981. Of these, 335 cases have been counted since January of 1985, about the time that the position of Medical Director became full time. Following is a categorization of the 335 cases occurring since January, 1985:

Status	Number	Percent of Total (%)
Cases under development	73	22
Hospitalized for evaluation or treatment as of report date	19	6
Inappropriate for program	20	6
Discharged or refused program and reported to DPR	12	4
Completed 28-day program; refused extended care	11	3
Successfully completed treatment and enrolled in aftercare	125	37
Enrolled in program in recovery	19	6
Treated outside Florida; reported to program in Aftercare	10	3
Treated and not reported to program and subsequently requiring services of program	16	5
Re-enrolled in program after coercive reporting	2	0
Deaths, including suicide	5	1.5
Psychiatric protocol (sexual)	5	1.5
Psychiatric protocol	10	3
Deaths / suicide attempts prior to intervention	1	0
Awaiting final disposition	5	1.5
Deaths in recovery not related to impairment	1	0
Referred to DPR for investigation	1	0
	335	100

3. **Family Care:** Experience has demonstrated the need for a strong, effective family component of PRN. Approximately 40 percent of the physicians in the program have been reported by family members or others emotionally involved with the patient. Family issues are a major factor in relapse. The support and involvement of the entire family greatly increases the impaired professional's chances for recovery. The program must continue to make the family part of the recovery process. Without family recovery from the effects of living with chemical dependency, the medical family is at high risk for relapse in the recovering physician, failure of marriage in recovery, spouses remaining untreated for their own chemical dependency and other adverse occurrences.

In order to focus on and deal effectively with family issues, PRN has engaged a Family Component Consultant.

4. **FMA Resolution 87A-17 (Physically Challenged Physicians):** At the request of the Board of Governors, the PRN Committee reviewed FMA Resolution 87A-17, which was not adopted by the 1986 House of Delegates but was referred to the Board for study. The resolution would have the FMA develop programs for physically disabled physicians. The Committee agreed that such a program would be a worthwhile undertaking and suggested that the Board consider establishing a special committee to develop a program for this group of physicians.

5. **Extended Treatment:** The Committee endorsed extended treatment (up to four months or more) for every physician entering the PRN program unless the treatment facility, on an individual basis, believes a shorter period is adequate. The Committee took this position in view of the fact that many physicians entering treatment have the impression that only the standard 28-day regimen is necessary when, in fact, many patients require longer therapy.

6. **FMA Section on Chemical Dependency:** For the seventh consecutive year, the PRN Committee, in partnership with the Florida Chapter of the American Medical Society on Alcoholism, will sponsor a Scientific Section on Chemical Dependency at the FMA Annual Meeting. The program will be offered on Wednesday afternoon, September 16, at the Diplomat Hotel.

FLORIDA PHYSICIANS ASSOCIATION, INC.

Charles J. Kahn, M.D., President
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

During 1986-87, the Florida Physicians Association (FPA) greatly expanded its operations. The FPA began the year by instituting a contract review and negotiation service for physicians. That service has completed numerous contract reviews and has engaged in negotiating more favorable contractual provisions for individual physicians and for physician-organized individual practice associations (IPAs).

We found that in many cases, physicians wanted the strength that comes from collective bargaining. Unfortunately, collective bargaining activities are, for the most part, illegal under the anti-trust laws.

One legal alternative which physicians can utilize in some cases is the formation of an individual practice association. If properly structured, an IPA can give physicians the bargaining power that comes from collective action and can enable them to remain competitive in the changing medical market.

The major problems with IPA formation have been the expense involved, the time it takes to organize, and structures which are not in the best interest of physicians.

As an adjunct to our contract negotiation service, we have now begun assisting groups of physicians seeking to form an IPA. We recently completed formation of a single specialty IPA in less than six weeks and at a cost significantly below what the IPA would have paid private attorneys or accountants. We are now negotiating on behalf of that IPA with several HMOs and PPOs. Most importantly, the IPA was structured in such a way so as to protect the individual physicians involved by keeping control of the IPA in the hands of the physicians themselves and by keeping on-going operational expenses virtually non-existent.

FLORIDA MEDICAL POLITICAL ACTION COMMITTEE

R. Benjamin Moore, M.D., Vice President
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

Political Action Program - 1986

The 1986 election cycle was very successful for FLAMPAC. The Board agreed upon a strategy early in the year which attempted to accomplish specific objectives.

There was a large number of open seats in legislative races. Consequently, the first goal was to identify and cultivate legislative friends in these open seats. In open seats in the House and Senate, FLAMPAC won 43 races and lost 14 during the primaries and general election.

Support for friends of medicine was another major goal for 1986. FLAMPAC supported 75 successful incumbents, lost by supporting two incumbents, unsuccessfully opposed seven incumbents and successfully opposed one incumbent.

Another objective for 1986 was increased participation at the local level in campaigns by physicians and spouses. Physicians throughout the state responded by making individual contributions to campaigns in record numbers. In many counties, physicians were active in all types of grass roots activity as needed by the campaigns.

There was a large number of "medical family" candidates in 1986. While all of these candidates were not successful, FMA-A member Betty Metcalf was re-elected from Dade County and FMA-A member Susie Guber was elected to her first term from Dade County — both in the House of Representatives. Additionally, Representative David Thomas, M.D., was re-elected without opposition from Charlotte County, and Representative Brian Rush, who is the son of a physician, was elected to his first term from Hillsborough County.

In Congressional races, FLAMPAC supported 17 congressmen, all of whom were successful in their re-election bids.

FLAMPAC broke from tradition this year by supporting a candidate for Governor, Bob Martinez. In addition to a direct PAC contribution, hundreds of physicians throughout the state responded by working in the campaign and by making direct contributions totalling well over $250,000.

Additionally, FLAMPAC continued to expand upon its services to candidates in addition to money. This election cycle we offered direct mail, polling, consultation and planning services to both the candidates and political parties.

Membership

Final FLAMPAC membership totals for 1986 were 4,752. This was slightly below the 1985 year-end total. However, contributions were more than adequate to fund FLAMPAC operations and ensure a strong organization.

FLAMPAC received two awards from AMPAC for membership achievements in 1986. These were:
- Second Place in Total Contributions Category
- Third Place in Membership to Potential Category

Flampac Officers and Board

The FLAMPAC Board of Directors elected the following officers for 1987:
- Luis M. Perez, M.D., President
- R. Benjamin Moore, M.D., Vice President
- Juan A. Wester, M.D., Secretary
- Donald G. Nikolaus, M.D., Treasurer
- Donald C. Jones, Assistant Treasurer

NOTE: Due to the illness of Luis M. Perez, M.D., R. Benjamin Moore, M.D., is serving as Acting President.

The FMA Board of Governors has appointed an outstanding list of physicians and Auxilian members to serve on the Board of Directors during 1987. These are as follows:

1st William W. Thompson, M.D.
2nd Terence P. McCoy, M.D.
3rd Mrs. James H. Corwin
4th James G. White, M.D.
5th Richard J. Bagby, M.D.
6th Frank R. Wilkerson, Jr., M.D.
7th Frank C. Coleman, M.D.
8th James L. West, M.D.
9th Donald G. Nikolaus, M.D.
10th John W. Glotfelty, M.D.
11th Brian P. Gibbons, M.D.
12th Donald Ames, M.D.
13th Donald C. Kiehl, M.D.
14th Dick L. Van Eldik, M.D.
15th T. Wallace Hahn, M.D.
16th Stanley I. Margulies, M.D.
17th James W. Bridges, M.D.
18th William I. Roth, M.D.
19th Warren Lindau, M.D.

Three From FMA Auxiliary
Mrs. B. David Epstein
Mrs. Arthur L. Eberly
Mrs. Don E. Sokolik

Two From FMA Board of Governors
Yank D. Coble, Jr., M.D.
Luis M. Perez, M.D. (Kay K. Hanley, M.D., is representing the Board during Dr. Perez's absence.)

Two From Committee on State Legislation
Thomas M. Daniel, M.D.
Louis C. Murray, M.D.

Six From State-At-Large
H. Quillian Jones, Jr., M.D.
R. Benjamin Moore, M.D.
Carlos G. Llanes, M.D.
Juan A. Wester, M.D.
Alvin E. Smith, M.D.
Richard S. Hodes, M.D.

Auxiliary President-Elect (ex-officio)
Mrs. Rex Orr

REPORT OF THE TREASURER

Yank D. Coble Jr., M.D.

(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

(Report not printed)

COUNCIL ON LEGISLATION

Louis C. Murray, M.D., Chairman
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

Most of the work of the Council on Legislation is accomplished through activities of its two committees: the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two major committees.

Committee on National Legislation

During the 99th Congress, the FMA Committee on National Legislation worked actively with the AMA Washington Office in seeking support for tort reform and in opposing several Medicare revisions that would have been detrimental to patient care in Florida. Among the issues that these efforts favorably impacted upon were:

- **Fee Freeze** — The Medicare fee freeze for nonparticipating physicians was ended.
- **Health Planning** — The federal health planning program has been repealed.
- **Professional Liability** — AMA-developed legislation to provide incentive grants for state tort reform was introduced in Congress with a number of co-sponsors and hearings in major committees.
- **Doctor Draft** — Legislation that would have established a health professions draft registration was defeated.
- **Champus** — Implementation of a nation-wide capitation system and competition contracting for Champus care was slowed. Instead, partial demonstration of this concept will be conducted.
- **PAC Limitations** — Amendments to inappropriately limit PAC contributions were not enacted.
- **Vaccine Compensation** — A bill passed the Congress that would, consistent with Association's policy, establish a no-fault compensation system for individuals injured due to mandated pediatric vaccines.
- **Graduate Medical Education Funding** — Efforts to reduce Medicare funding for graduate Medical Education from a maximum of five years to a maximum of four years were defeated.

Major efforts began early with the 100th Congress in opposing mandatory assignment for Medicare and the proposal for establishment of a DRG system for reimbursement of physicians. The major focal point for this was the co-sponsorship of Resolutions in the House (House Concurrent Resolution 30) and Senate (Senate Concurrent Resolution 15). Seventeen of Florida's House members and Senator Bob Graham signed on as co-sponsors.

The FMA played a major role in getting the AMA to gain support for modifications to the PRO program, particularly in the areas of due process and in notification to patients concerning disallowance for medical procedures or hospital stays.

The Committee plans to be very active during the summer and early fall in monitoring, and reacting to, the issues that will develop in the Budget Reconciliation process and the efforts by some in Congress to place even greater restrictions on physicians who provide care to Medicare recipients.

Committee on State Legislation

The Committee on State Legislation has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Six formal meetings of the Committee have been held along with informal conferences among Committee members as items of an urgent nature arose.

Consistent with the policies developed by the FMA House of Delegates, the Committee has worked closely with the Board of Governors in accomplishing our legislative objectives for the 1987 session of the Florida Legislature.

The following items summarize the Committee's activities:

1. The legislative program is continuing to function under the supervision of Donald S. Fraser Jr., Deputy Executive Director, Legislation and Public Affairs. He has been materially assisted by Ms. Lucy Mohs, Assistant Director of Legislative Affairs, and George S. Palmer Jr., Assistant Director of Legislative Affairs. Particularly helpful to the legislative activity has been the FMA Field Offices. These have greatly increased the Association's ability to maintain liaison with county medical societies, contact physicians, specialty organizations and members of the Legislature.

2. The Capitol Dispensary. The Committee placed major emphasis on working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Linda Bass, R.N., head of the clinic, has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the "Doctor of the Day" program.

3. The Committee on State Legislation. This Committee is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. In addition, priority attention has been directed toward increasing the role of the Auxiliary in the Association's efforts.

4. Publications. A legislative bulletin was published every week during the legislative session and periodically between sessions. The bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A listing of all bills monitored by the Capital Office is sent on a regular basis to county medical society executives and legislative chairmen. In addition, summaries and copies of key legislative proposals are distributed.

5. **1987 Legislative Accomplishments.** During the 1987 legislative session, there were more than 360 legislative proposals that required action by the Committee on State Legislation or the Capital Office. Matters of major interest to the Florida Medical Association were:

 Professional Liability Insurance

 The 1987 Legislative Session adjourned without resolving the professional liability crisis. During the session several proposals were filed that required the active involvement of the Florida Medical Association.

 Gunter Plan

 This proposal creates the "Florida Hospital and Physicians Liability Association" to write coverage for all Florida hospitals and physicians. All physicians would be mandated to carry professional liability insurance as a condition for licensure. This mandate would eliminate the private market option. Underwriting deficits would be funded by assessments against fund participants. Under the Gunter Plan the cost of the first $250,000 of liability for acts performed by a physician on the staff in a hospital would be paid for by the hospital. Non-hospital liability coverage would be paid for by the physician. The FMA was successful in opposing the Gunter Plan.

 Simon Plan (SB 974, HB 1146)

 This legislation creates the Medical Malpractice Premium Stabilization Trust Fund to be administered by the Department of Insurance. Subsidization of premiums would occur for a physician whose medical malpractice premiums exceed ten percent of the physician's gross income derived from the delivery of medical services. Underwriting deficits would be funded by assessments against the fund participants. The Florida Medical Association was successful in opposing this concept.

 Odgen Plan (CS/HB 1458)

 This proposal requires coverage to be purchased by all physicians and hospitals through the Florida Medical Malpractice JUA with no private market options after July 1, 1988. This legislation also contains a "channelling" provision that makes a hospital liable for the first $250,000 of a hospital staff member's negligence. The Ogden Plan increases the cost for a majority of physicians to subsidize physicians in high-risk categories. Underwriting deficits would be subsidized from homeowners and other casualty insurance carriers. The Florida Medical Association was successful in opposing CS/HB 1458.

Issues Opposed by the Florida Medical Association Which Were Defeated In The 1987 Legislative Session:

- Mandatory Medicaid assignment as a condition for licensure (SB 179, HB 275).
- Mandatory acceptance of chiropractors' patients referral to hospital outpatient diagnostic facilities (SB 299, SB 1069, HB 134).
- Mandatory hospital staff privileges for chiropractors (SB 299, SB 1070, HB 133).
- Authority for chiropractors to inject vitamins (SB 216, HB 138).
- Expansion of accessibility to patients' records (SB 1213, HB 931).
- Reenactment of licensure of lay midwives (SB 915, HB 820).
- Statutory modification of "Patient's Bill of Rights" (SB 1213).
- Authority for patient to request laboratory work and subsequent report without physician referral (SB 1086, HB 228).
- Further restrictions on physicians dispensing drugs or providing complimentary samples.
- Expansion of the Certificate of Need program to include equipment in a physician's office.
- Licensure of dietetics (SB 120, HB 423).
- Creation of certified absorptionmeter operator (SB 148, HB 633).
- Authority for Department of Professional Regulation to obtain physicians' records without subpoena (SB 950, HB 1380).

Issues On Which The Florida Medical Association's Position Was Sustained:

- Support for protection of profit sharing, pension plan funds (CS/SB 433).
- Support for sales tax exemption of health professional services.
- Support for comprehensive indigent health care program (CS/HB 1384).
- Support for improved trauma center verification system (CS/SB 1098 & 296).
- Opposition to removal of the oral examination requirement for certain physicians in Chapter 458, F.S., Medical Practice Act.
- Support for liability protection for officers, directors and trustees of for-profit and not-for-profit organizations, associations and corporations (CS/SB 1096, 963 & 654).
- Opposition to "sundown review" changes to Medical Examiners Commission.
- Support for improved quality of care requirement for HMOs (CS/HB 1385).
- Support for gradual phaseout of Certificate of Need program.
- Support for modifications to the Professional Service Corporations Act to permit rather than require the corporate name of professional service corporations to contain the last names of shareholders (HB 207).
- Support for the limitation of time during which physicians could receive preferential licensure treatment (CS/HB 1221).

Issues On Which The Florida Medical Association's Positions Were Not Sustained:

- Support for liability protection for trauma and emergency room physicians (SB 378, HB 701).
- Support for extending sovereign immunity for physicians contracting with the State (SB 251, CS/SB 1036, HB 136).
- Support for authority for physicians to negotiate workers' compensation rates with employers (SB 1071).
- Opposition to preferential licensure treatment for physicians practicing in Cleveland Clinic (CS/HB 1221).
- Support for increased funding for Florida Cancer Control and Research Advisory Board (CCRAB).
- Support for liability protection for physicians providing physical examinations for athletes or providing medical care during sports events.

Other Health Legislation Passed By The Legislature:

- Authorizes Division of Workers' Compensation to assess a civil penalty against a carrier which deauthorizes a health care provider who has been authorized by the employer without approval (CS/SB 167).
- Rewrites 14 workers' compensation sections of law subject to Sunset Review (SB 820).
- Authorizes a non-profit organization, as well as a non-profit foundation, to conduct peer or utilization review of health care services (CS/SB 821).
- Requires individual and group health insurance policies that provide acupuncture to cover the services of a certified acupuncturist under the same conditions as a licensed physician (SB 367).
- Requires the Department of Administration to contract with HMOs to participate in the state health group insurance plan through competitive bidding (CS/HB 195).
- Requires group health insurance policies providing coverage on an expense-incurred basis to provide coverage for home health care by a licensed home health care agency (HB 595).
- Requires health insurance policies providing optional coverage for mastectomies on or after October 1, 1987, to provide optional coverage for related surgical procedures and devices (HB 595).
- Requires anyone seeking mandated benefits to provide appropriate legislative committees with information relating to the social and financial impact of the proposed legislation (CS/HB 619).
- Regulates the formation or operation of insurance risk retention groups and purchasing groups (HB 649).
- Provides that decertification of treatment of a person in a personal injury protection case can only be done by a like practitioner without the consent of the injured person (HB 649).
- Expands the offer of judgment concept set forth in Section 768.79, F.S., to offers of settlements and provides sanctions for the unreasonable rejection of settlement offer made by either party (SB 866).
- Expands immunity to other persons who report insurance fraud (CS/SB 908).
- Limits liability for, and discovery from members of the Correctional Medical Authority, and employees, agents, and consultants for the Department of Corrections when they are part of a committee formed to evaluate and improve the quality of health care rendered to inmates (CS/SB 1161).
- Provides that in a civil action based on misconduct in a commercial transaction, the amount of punitive damages shall not exceed three times the amount of compensatory damages awarded (CS/HB 343)

- Provides procedures for court-ordered mediation, court-ordered nonbinding arbitration, and voluntary binding arbitration (CS/HB 379).
- Expands the information included in the written notice of a violation of the Insurance Code which a person must provide to the Department of Insurance and the insurer prior to bringing a civil action against the insurer (HB 428).
- Requires the annual approval of fees for "911" emergency telephone service (HB 522).
- Requires the Chiropractic Peer Review Committee to field a complaint with, and transmit information to, the Department of Professional Regulation when reasonable cause exits for which disciplinary action may be taken (CS/SB 873).
- Provides for the regulation of clinical social workers, marriage and family therapists, and mental health counselors (CS/HB 58).
- Requires registration rather than licensure of manicurists, pedicurists, and persons performing facials (CS/HB 376).
- Requires dentists administering anesthesia to have a certification in either CPR or advanced cardiac life support (CS/HB 918).
- Continues hearing aid specialist trainees in trainee status until receipt of the practical examination results (HB 1256).
- Changes the eligibility requirements for licensure by endorsement for nurses to delete the provision relating to comparison of Florida's current licensing standards of another state (HB 1438).
- Requires the Medical Examiners Commission to adopt rules providing for notification of the next of kin that an investigation by the Medical Examiners office is being conducted (CS/HB 338).
- Requires that certain statutorily created boards, councils, and commissions include a member who is 60 years of age or older (CS/HB 374).
- Exempts the state and federal financial participation portion of Medicaid earnings from required local matching funds for community alcohol and mental health services and programs (CS/HB 603).
- Requires the review of the placement of a minor in a mental health unit by the attending physician or a designee or an on-call physician each day with documentation provided in the case record (CS/HB 931).
- Provides technical corrections and clarifications of the fingerprinting and screening provisions of Florida law (HB 1409).
- Creates the Florida Employment Opportunity Act providing for the increased training, education, and employment opportunities for an estimated 100,000 public assistance applicants and recipients (HB 1428).
- Creates and establishes in law Prescribed Pediatric Extended Care (PPEC) Centers and provides for their licensure by Department of Health and Rehabilitative Services (HB 1453).
- Requires nursing homes to provide a copy of records to the spouse, guardian, or responsible party of a current or former resident upon request, unless expressly prohibited by a legally competent resident (CS/SB 168).
- Provides for a directed blood donor program whereby the blood of specific donors can be used by a designated recipient in future blood transfusions (CS/SB 234).
- Designates financial and actuarial information provided to the Department of HRS by providers and insurers that participate in Medicaid prepaid health care plans as proprietary confidential business information that is not subject to public disclosure (SB 380).

- Provides for future repeal and legislative review, pursuant to the Sundown Act, of the provisions of the law relating to advisory bodies adjunct to executive agencies (SB 389).
- Requires Department of HRS and Department of Insurance to cooperatively provide information relating to third party benefits for public or medical assistance recipients (CS/SB 515).
- Rewrites chapter 382, Florida Statutes, Vital Statistics Law (CS/SB 693 & 561).
- Authorizes the 18 regional Florida Diagnostic Learning Resources Systems (FDLRS) centers to provide testing and evaluation services for handicapped infants and preschool students (SB 1128).
- Authorizes the Governor to designate a private, non-profit corporation to receive federal funds for the implementation of the Florida Protection and Advocacy System (CS/SB 1181).
- Clarifies that physician services in HMOs are those provided by medical doctors, osteopaths, podiatrists and chiropractors (CS/HB 121).
- Exempts the Shriners Hospital for Crippled Children in Tampa from the uniform financial reporting requirements until it receives revenues from or on behalf of any individual patient. (SB 39).
- Authorizes the Lee County Board of Commissioners to establish an additional public hospital in the county (SB 1293).
- Provides for a Supreme Court advisory opinion on whether the text or ballot title of a proposed constitutional amendment or revision complies with the constitution (SB 209).
- Allows that certifying the disability of applicants for disability retirement under the Teachers' Retirement System of Florida can be performed by any licensed physician in the State (HB 291).
- Clarifies application of the child restraint law by specifically exempting school buses, transit buses, farm tractors, large trucks, motorcycles and mopeds (HB 775).
- Amends the "Solicitation of Charitable Contributions Act" and "Law Enforcement and Emergency Services Solicitation and Contributions Act" (HB 780).
- Requires reporting to the Sheriff's Office under certain conditions the treatment of burn victims with second or third degree burns affecting 10 percent or more of the body (HB 1205).
- Complies Florida's description of dronabinol with the Federal schedule of controlled substances (SB 112).
- Recreates and renames the Florida Governor's Council on Physical Fitness and Amateur Sports (SB 227).
- Requires organ donor registration cards be maintained on microfilm and that hospitals request organ donations including eye and cornea from the family of a person near death (SB 377).
- Provides that certain sections of the State Comprehensive Health Association Act are not repealed October 1, 1987 (SB 504).
- Creates the Lee Moffitt Cancer Center at the University of South Florida (CS/SB 757).
- Removes homemaker services from the definition of "home health services" under the Home Health Services Act (CS/SB 787).

Items Contained In SB 1325, The General Appropriations Bill, Of Interest To The Florida Medical Association:

- Appropriation up to $300,000 to be used in contracting with the Florida Medical Foundation, Inc. for the purpose of providing consulting services for the Impaired Physicians Program (compared to $100,000 in 1986).
- Appropriation of $6,156,268 from General Revenue Fund to continue the Community Hospital Education Program (compared to $5,913,802 in 1986).

- Appropriation of $10,139,010 from General Revenue Fund and Maternal and Child Health Block Trust Fund for Improved Pregnancy Outcome (compared to $9,843,699 in 1986).
- Appropriation of $1,408,000 from General Revenue Fund for 320 students at the Southeastern College of Osteopathic Medicine (compared to $1,208,000 for 302 students in 1986).

SUPPLEMENTAL REPORT OF THE COUNCIL ON LEGISLATION
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

DRG's for Radiologists, Anesthesiologists, and Pathologists

On July 23, 1987, the U.S. House of Representative's Ways and Means Committee led by Congressman Ron Flippo (D-Alabama) rejected the proposal to expand DRG's for radiologists, anesthesiologists, and pathologists. The 26-9 rejection vote was a significant victory for organized medicine. Underscoring this anti-DRG sentiment is the support from 17 of Florida's 19 Congressmen for House Concurrent Resolution 30 (CHR 30) and Senator Bob Graham's co-sponsorship of Senate Concurrent Resolution 15 (SCR 15). Both concurrent resolutions oppose DRG's for RAP's. HCR 30 co-sponsors are:

Congressman Charles E. Bennett
Congressman Michael Bilirakis
Congressman Bill Chappel, Jr.
Congressman Dante B. Fascell
Congressman Sam M. Gibbons
Congressman Bill Grant
Congressman Earl Hutto
Congressman Andy Ireland
Congressman Tom Lewis
Congressman Buddy MacKay
Congressman Connie Mack
Congressman Bill McCollum
Congressman Dan Mica
Congressman Bill Nelson
Congressman E. Clay Shaw, Jr.
Congressman Larry Smith
Congressman C. W. Bill Young

Catastrophic Health Insurance

A highly controversial Catastrophic Health Insurance proposal passed the House of Representatives and is poised for further debate in the U.S. Senate. The controversy centers on the means of funding such a concept. In addition, the Senate is expected to focus on the issue of the drug benefits proposed in the package, specifically, the unstated preference for generic drugs instead of brand name drugs.

Bar on Physician Drug Dispensing

The House Energy and Commerce Committee favorably reported HR 2168 which contains a provision that should prohibit physicians from dispensing for a profit a drug which is to be taken orally and which is not a vaccine except under the following limited circumstances:

— it is for emergency medical reasons or when in the physician's judgment, the patient has substantial difficulty in obtaining drugs from a pharmacy; or

— it is prescribed by physicians practicing in rural areas.

Drug samples are not included in this bill. In a recent development the Committee has not filed its report on HR 2168 thereby, according to House Rules, preventing the bill from being debated on the House floor.

COUNCIL ON MEDICAL ECONOMICS

Charles P. Hayes Jr., M.D., Chairman
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED

The Council on Medical Economics held three meetings during the 1986-87 Association year: September 3, 1986; January 21, 1987; and May 28, 1987. The Council reviewed many medical economics issues during the Association year with major emphasis being placed on proposed indigent care legislation and the Medicare mandatory assignment law.

The Committee on Workers' Compensation was actively involved in developing proposed legislation to allow physicians to contract directly with various employers and Workers' Compensation insurers to develop an alternative to the current system of reimbursement under the Workers' Compensation fee schedule.

The Committee on Peer Review Organizations reviewed major problems the membership has encountered with Medicare admission and hospital denials throughout the Association year.

The Committee on Relative Value Studies completed the 1986 Florida Relative Value Studies and prepared to complete a new edition of the Relative Value Studies.

The Ad Hoc Committee on Prepaid Plans spent a tremendous amount of time in addressing the recommendation from the Board as to the feasibility of the FMA developing a management services company that included the development of a strategy and plan of action that could be used by physicians individually and collectively in competing with alternative delivery systems.

Mandatory Medicare assignment was a key legislative issue that was ultimately defeated during the 1987 legislative session. The Council recognizes that there is a strong possibility that the Medicare assignment legislation will come up again during the 1988 legislative session and will have a stronger chance of passage unless the FMA can develop some type of agreement with the American Association of Retired Persons with regard to their concerns over the accessibility and affordability of medical care for senior citizens.

The Council also recommended that a survey be conducted of practicing physicians in Florida with regard to the amount of indigent health care they provide in their offices. This survey was completed by the Center for Health Policy Research at the University of Florida which provided some significant state of the art information with regard to health care being provided by Florida physicians to indigent citizens. The Committee on Indigent Care intensely studies the financing and delivery of indigent care. The study is the first of its type ever conducted in the United States. It concluded that between $268 million or $19,800 per physician and $477.2 million or $35,000 per physician worth of uncompensated care are provided annually by physicians in Florida.

Committee on Workers' Compensation

The Committee on Workers' Compensation met twice during the Association year to address the issue of reimbursement under the Workers' Compensation program. As a result of the study developed by John Lewis, Esquire, an attorney retained by the FMA who has written Workers' Compensation laws for several states, it was recommended that the FMA secure passage of legislation and related regulations that will permit alternative contractual arrangements between payors and physicians providing services within the Workers' Compensation program.

During the 1986 Annual Meeting, an emergency resolution was adopted by the House that requested the FMA to immediately investigate the circumstances concerning the delay in publication of the 1986 Florida Workers' Compensation reimbursement schedule. It was brought to the attention of the FMA that the Office of Medical Services under the Division of Workers' Compensation was awaiting approval from the AMA to utilize the CPT-4 nomenclature in their fee schedule. Within a matter of days the FMA received written approval by the AMA for the Office of Medical Services to utilize the fee schedule. The FMA was then advised that the Department of Insurance had requested the Office of Medical Services

to delay the proposed increase in the Workers' Compensation fee schedule because of the inaccuracies that they had identified in the data base. As a result, the implementation of the 1986 fee schedule has been further delayed and is currently being updated to be submitted to the Three Member Panel for approval. In May, 1987, FMA staff met with representatives of the Office of Medical Services for the purpose of reviewing the current status of the revision of the Workers' Compensation data base. The Office of Medical Services has advised the FMA that the data base will be submitted to the Three Member Panel by June 1, 1987, for their consideration and that the new fee schedule could be implemented in approximately three to four months after the Three Member Panel has taken action on the fee schedule.

The Chairman of the Committee on Workers' Compensation, Howard A. Kurzner, M.D., met with the FMA State Committee on Legislation on January 4, 1987, for the purpose of introducing the proposed concept of amending the Workers' Compensation law that would allow physicians the opportunity to negotiate with insurers or employers to provide Workers' Compensation services. The amendment would provide for a schedule of maximum charges provided by written contract between the hospital or health care provider and the self-insurer or insurer. Individual hospitals, health care providers, or payors may join together in order to form efficient bargaining units for the purpose of contracting for the delivery of health care services. The amendment would also allow for contract provisions for peer review of charges and the quality of care that is rendered. During the legislative session, FMA staff, along with John Lewis, Esquire, met in Tallahassee to discuss the strategy implementing the proposed legislation and met with the Senate and House Commerce Committee staff to further discuss the proposed legislation. The proposal was developed as a result of the resistance the FMA has experienced in trying to obtain more equitable reimbursement for providing Workers' Compensation services based on the fee schedule that is set by the Three Member Panel. This concept does not eliminate the current law but allows for an alternative for the employer and insurer to enter into.

On May 12, 1987, FMA staff and John Lewis, Esquire, met with representatives of the Associated Industries of Florida, Chamber of Commerce, Florida Association of Insurance Agents, State Commerce Committee, Communications Workers of America, Department of Insurance and the Florida AFL-CIO to discuss the proposed amendment to the bill. Every single representative attending this meeting stated that, to date, there had been no accounts of inaccessibility to quality medical care to their employees who were covered under the Workers' Compensation Program. The Insurance Department stated that this proposed amendment would only be inflationary and cause medical costs to skyrocket and ultimately increase Workers' Compensation premiums. The consensus of the group was that they could not support this proposed concept and that they would vehemently oppose the bill once it came to committee. Subsequently, due to the lack of support expressed by the various interest groups, it was felt that the proposed amendment would not pass in the Legislature.

Historically, the FMA has encountered major obstacles in seeking equitable reimbursement for providing Workers' Compensation services through the Three Member Panel which sets the percentile in which the fee schedule is to be based. The Committee on Workers' Compensation will be conducting meetings during the summer to address other alternatives in addressing the reimbursement issue as well as determining other methods in which the proposed amendment to the Workers' Compensation law could be passed.

The Committee felt that in view of the problems inherent in the Workers' Compensation medical fee schedule, and that with alternative mechanisms already beginning to be implemented within the Workers' Compensation system, that it was imperative for the FMA to take the lead role in the development of a mechanism to allow physicians the opportunity to negotiate with third party payors in the delivery of services to Worker's Compensation patients.

Committee on Peer Review Organizations

The Committee on Peer Review Organizations, chaired by Arthur E. Eberly, M.D., continued in the role of monitoring the activities of the Professional Foundation for Health Care, Inc. (the statewide PRO). During the Association year, the Committee regularly communicated to the membership their need to submit individual problems that they have encountered with the PRO.

During the 1986 Annual Meeting, a great deal of discussion was directed at the quality of physician reviewers which the Professional Foundation for Health Care was using. The Committee, in recognizing this fact, recommended that the FMA encourage the membership to volunteer to become physician reviewers for the Professional Foundation for Health Care. This recommendation was adopted by the FMA Board of Governors and was communicated to the FMA membership.

The Committee reviewed several problems that have been encountered by the members regarding technical errors. On several occasions physicians have had admissions denied with no appeal mechanism available because their signatures did not match the attestation statement signature or the date on the claim form was not correct. It was felt that current regulations need to be amended to allow for correction of technical errors rather than the physician and patient being punished by an admission denial. This recommendation was communicated to the AMA. The Committee reviewed several complaints received from the membership with regard to unjustified admission denials. In several instances, the Committee agreed with the position of the physician and requested that the PRO rescind the admission denial. Several of these cases were reversed.

In addition, the PRO Committee was informed by the Professional Foundation for Health Care that the current quality denial letters being utilized by the PRO to advise the patient of admission denials had been withdrawn. The Committee recognized the importance of drafting these letters for the PRO to be submitted to the Health Care Financing Administration. The FMA would submit proposed denial letters to help provide guidance and eliminate any misconceptions about the quality of care rendered by a physician, which could cause damage to the doctor/patient relationship and give rise to a medical malpractice claim.

During the Association year, a special Advisory Committee composed of members of the FMA PRO Committee who, are not members of the Professional Foundation for Health Care Board, was established. This Advisory Committee has met once with the PRO and it is felt that the Advisory Committee would be able to provide assistance in reviewing questionable records in which the Foundation was unsure whether an admission should be denied, or in reviewing records that are being considered for possible sanctions.

The Committee recommended that the FMA continue to review and identify individual complaints received from the membership with regard to specific problems they have encountered with the PRO and develop potential resolutions to these problems so the physician would not be having to take unnecessary time in getting necessary admissions justified through the lengthy and time consuming reconsideration process.

The Committee also recommended that the AMA request the Health Care Financing Administration to revise the current sanction process to allow for adequate due process for physicians being considered for a sanction and appropriate administrative hearings be exhausted before a sanction is issued. It was brought to the attention of the FMA that the inequities in the sanction process do not allow adequate due process for the physician in the sanction review and that it was necessary that the current regulations be revised to allow for adequate due process to be implemented into the sanction review process. The FMA contacted the AMA about the problem identified with the sanction process. Subsequently, the AMA contacted the HCFA and was successful in having the sanction process amended to increase appropriate administrative hearings that would allow the physician to have adequate due process in the administration of sanctions.

Committee on Relative Value Studies

During the summer of 1986, the Committee on Relative Value Studies completed the development of the 1986 Florida Relative Value Studies. As of May 26, 1987, over 8,000 copies of the 1986 Florida Relative Value Studies had been distributed to Florida Medical Association members or sold to other individuals or companies. To date, there have been 10,000 copies of the Relative Value Studies printed. It is anticipated that another 5,000 copies will need to be printed to satisfy the current demand for the 1986 edition. The Committee on Relative Value Studies is currently reviewing many of the relativity not established (RNE) procedures that are present in the 1986 Florida Relative Value Studies in an effort to assign specific relative values. It is anticipated that the Committee will complete the revision of the current RNEs sometime during the summer of 1987.

The Committee also acknowledges the fact that William H. Dodd, Senior Vice President of Blue Cross and Blue Shield of Florida, Inc., has greatly contributed to the development of the Relative Value Studies over the past twelve years and has recommended to the FMA that a commendation be made to William H. Dodd for his continued efforts in providing input and expertise in the development of the Relative Value Studies.

Ad Hoc Committee on Prepaid Plans

The Ad Hoc Committee on Prepaid Plans previously reviewed and studied several options for the FMA to consider with regard to alternative delivery systems. As a result of Resolution 85-2 entitled "Alternative Delivery Systems," that asked that the FMA place more emphasis on providing information to its membership regarding alternative health delivery systems and called for the development of a strategy and plan of action that could be used by physicians individually and collectively in competing with these systems and that appropriate funding and staffing be added to bring this program into fruition, the Council on Medical Economics developed a feasibility study on prepaid plans which was reviewed by the Board of Governors during October, 1985. As a result of this feasibility study, the Ad Hoc Committee on Prepaid Plans was developed to further study the FMA's role in this effort. The three options for the FMA to consider included the development of a network of existing and developing county medical society sponsored HMO/IPA plans, the feasibility of joint ventures with insurance companies, statewide and national HMO/IPA Plans, or with other related entities and the feasibility of providing financial assistance to the development of physician sponsored prepaid plans in Florida.

Subsequently, the Committee felt that the creation of a management services company would provide a combination of all three options previously discussed as well as allow physician leadership in the development of a management services company.

The Ad Hoc Committee on Prepaid Plans discussed in detail the proposal developed by Judith Mattson of Judith Mattson, Inc., the consultant retained by FMA to assist in their study to determine the role of FMA involvement in prepaid plan activity. The proposed study involved four stages: the preliminary study and analysis was conducted by the FMA as a result of the 1984 resolution from the House of Delegates. The feasibility study completed in September of 1985, was entitled "Feasibility Study of the FMA seeking to establish a Statewide Prepaid Health Care Plan." The next stage of the proposal was the business planning stage which involved examining the issues of operational medical policy viable to the design of the FMA programs to be organized under the management services company. The purpose of this activity was to incorporate physician input into each of the many organizational issues that need to be addressed in the formation of the management services company. Other areas of this stage include updating the survey of the Florida health care marketplace for the purpose of developing up-to-date information on the major entities involved in prepaid plan activity as well as the development of the proposed organizational structure for the management services company and to translate program requirements into predictable structures and cost for the purpose of projecting the financial operations of the proposed management services company.

The Committee recognized that the management services company is capable of serving as a focal point of all FMA support activities and services including the marketing and coordination among physicians of their alternative health plan arrangements throughout the state of Florida. The Committee recognized the major commitment that the FMA will be undertaking in the development of a management services company and the need to fully investigate and thoroughly research all feasible areas prior to making a final commitment to ensure that the needs of the members have been met and that the company can become financially self sufficient.

The Committee met several times during the Association year with Judith Mattson, Inc. to discuss the progress of this report. The completed report contains a business plan which includes a review of the Florida health care industry, recommendations on the development of a management services company including the services the company will provide, a time phase plan for implementation, and a detailed analysis of the financial requirements for capitalization of implementation of the management services company. The report placed special emphasis on the identification of changes in organizations and systems that impacted physicians' practices.

A series of interviews was conducted with selected organizations and individuals in January and February of 1986, representing major health care organizations in Florida. As a result of this year-long effort, a final proposal outlining the business plan for development of the Florida Medical Management Services Company was submitted. As a result of this proposal, the Committee made several recommendations for the FMA to consider that included that the FMA reaffirm the early decision to implement a program which aids physicians in their managed care, i.e., HMO, IPA and PPO, relationships but which is not itself any type of statewide managed care program. The survey conducted of the health care industry, clearly indicated the rapid escalation and proliferation of prepaid plan development in Florida

from both an HMO and PPO perspective. As a result, the committee recognized the risk the FMA would be taking in trying to establish some form of a statewide managed care program in the competitive health care market place that exists.

The Committee also recommended that the FMA approve, in concept, the Florida Medical Management Services Company and its self sustaining entity designed to address the day-to-day business concerns of the practicing physicians in a competitive health care environment; and that the management services company be established as a viable concept subject to policy concurrence by the FMA and approval of the suggested funding as outlined in the business plan.

Based on the final proposal, the Committee recommended that the FMA approve the continuation of this initiative through authorization of funding to complete the preoperational final development stage and implementation of the proposed company. The Committee, recognizing the various services that the FMA currently offers, recommended that they be incorporated into the management services company to save capital and strengthen the effectiveness for each related activity and proposed activity of each organization, in order to best serve the membership. The Committee recognized that they had deviated from the charge of determining the role of the FMA with regard to prepaid plan activity but recognized the value of the development of a management services company which would provide for a viable alternative to satisfy and provide the needs and services of physicians in a growing competitive health care environment.

Committee on Indigent Care

Charles B. McIntosh, M.D., served as Chairman of the Committee on Indigent Care, with Charles P. Hayes Jr., M.D., as Vice Chairman. The Committee held its organizational meeting on September 25, 1986, at which time it made several policy recommendations regarding FMA policy on indigent care. These recommendations were that the FMA: (1) continue support for a broad-based funding approach for the financing of indigent health care as well as a primary care and preventive medicine delivery system that emphasizes the coordination of public and private sector services to indigents; (2) seek enactment of legislation providing for county public health units to serve as brokers of indigent care to the private sector with provision for appropriate alternative brokers; (3) seek enactment of legislation that would include the extension of the state's limited waiver of sovereign immunity to cover physicians providing care to indigents on contract with county public health units and all physicians providing care to indigents through state and/or federally funded programs and insurance mechanisms; and (4) seek the enactment of legislation that will provide for increases in provider reimbursement levels for physicians, dentists, EPSDT (early, periodic, diagnosis, screening and treatment) and home health care services as recommended by the Department of Health and Rehabilitative Services.

The Committee held a meeting on October 30, 1987, at which a representative of the Department of Health and Rehabilitative Services gave an in-depth presentation on indigent care in Florida, the status of Florida's indigent population, and levels of income constituting poverty, as well as an overview of Florida's primary care programs. At this meeting, the Director of the Center for Health Policy Research, University of Florida, discussed the study of inpatient uncompensated care conducted by the Center for Health Policy Research in conjunction with the Florida Hospital Cost Containment Board. Also discussed was a forthcoming study of uncompensated care provided by physicians contracted for by the FMA with the Center for Health Policy Research, the first of its type in the nation.

The Committee participated in the FMA Symposium on Indigent Care, held November 24, 1986. Well over 100 persons attended the Symposium, representing more than thirty major health associations, state agencies, business coalitions, the three colleges of medicine in the state, other university faculty and administrators, as well as key legislators interested in indigent care. Speakers included state and national leaders on the subject. The Symposium consisted of three major segments: the perspective in Florida; the national perspective; and the perspective in other states. Members of the Florida Senate, Florida House of Representatives, and the Secretary of the Department of Health and Rehabilitative Services were also on the program.

At the February 19, 1987, meeting in Orlando, James B. Perry, M.D., FMA President, addressed the Committee, commending it for its work in developing an FMA approach to indigent care that emphasizes primary care and preventive medicine. The committee also received an overview on the indigent care financial and service delivery concerns and plans from representative of five hospitals in the state. They were: Lee Memorial Hospital, Ft. Myers; Orlando Regional Medical Center, Orlando; University Hospital, Jacksonville; Halifax Medical Center, Daytona Beach; and Mt. Sinai Hospital, Miami. Each of these

hospitals have major indigent and uncompensated care problems. A consensus viewpoint among the hospitals was that investment by the state in a primary care outpatient services program would significantly reduce the levels of uncompensated care now being delivered by hospitals. The Florida Hospital Association (FHA) further made a presentation describing a plan for indigent care agreed upon by the FHA, the Florida League of Hospitals, and the Association of Voluntary Hospitals. Included in the Hospital Associations' plan was the expansion of the state's primary care plan to all 67 counties.

The Committee held its fourth meeting of the 1986-87 FMA year on March 12, 1987. E. Charlton Prather, M.D., Acting Deputy Assistant Secretary for Health and State Health Officer, Department of Health and Rehabilitative Services (HRS), presented an overview of the history of indigent care provided by county health departments in conjunction with private practitioners of medicine in Florida, which formally began with the establishment of the Florida State Board of Health in 1889 and the subsequent evolution of county health departments in all 67 counties of the state. Directors of seven county public health units or their representative reported on the status and future of indigent care and primary medical care in the following counties: Broward, Collier, Dade, DeSoto, Duval, Palm Beach, Sarasota, and Volusia. Two county medical societies reported on their activities in indigent care. Representing the Hillsborough County Medical Association (HCMA) was John S. Curran, M.D., Chairman of the HCMA Health Planning Committee. Dr. Curran provided extensive data on the configuration of health care services in Hillsborough County as well as the results of a survey of HCMA members on indigent care and malpractice. Brian S. Edwards, M.D., Chairman, Indigent Care Committee, Lake County Medical Society, also gave a presentation on his county medical society's involvement in indigent care and support for the county public health unit and sovereign immunity features of House Bill 414 by Rep. Alzo Reddick, D-Orlando, and Rep. Tom Woodruff, R-St. Petersburg.

W. Ray Lynch Jr., M.D., F.A.C.E.P., Palm Bay, Brevard County, gave an overview of the practice of emergency physicians and the extent to which his group is involved in providing care to indigents. Dr. Lynch stressed the need to develop primary care alternatives to the emergency room for indigents, while at the same time establishing appropriate linkages between the emergency room and other health care resources in each community. Dr. Lynch further emphasized the need for liability coverage of emergency physicians who treat indigents by extending the state's limited waiver of sovereign immunity to emergency room physicians. George Rust, M.D., Chairman, Medical Directors Section, Florida Council of Primary Care Centers, discussed the 29 federally funded community health and migrant health centers in Florida. These 29 centers have 58 clinic sites in over half of Florida's counties. Last year, these centers saw 320,000 persons who had 857,655 medical visits. Dr. Rust also stressed the need for liability protection through sovereign immunity coverage. He emphasized that when dealing with limited financial resources, the most prudent and effective use of funds for indigent care can be made through investing primary care. Dr. Rust said that primary care can reduce utilization of emergency rooms, decrease hospitalization, and improve the health status of the indigent population in general.

Committee on Government Programs

Donald G. Nikolaus, M.D., served as chairman of the Committee on Government Programs. At its initial meeting on November 13, 1986, the Committee made several recommendations pertaining to: (1) continued support of the FMA position on the organization of the Department of Health and Rehabilitative Services; (2) the development of a Florida Public Health Code; (3) Medicaid provider reimbursement increases in the Governor's budget; and (4) assistance to HRS in conjunction with county medical societies in the mission of publicizing more information about AIDS to the public and health care providers. On May 1, 1987, the Committee met to consider a major item of concern to the FMA, which pertains to the Florida Medicaid Drug Utilization Review program. The Committee approved a recommendation that the FMA become formally and officially involved in the Medicaid Drug Utilization review of physicians through county and state level review processes, as may be appropriate and feasible. Currently, Medicaid Drug Utilization Review is being performed solely by the Florida Pharmacy Association with no involvement by the FMA. The committee further recommended that the FMA compile a roster of governmental appointments in which the FMA was asked to make an appointment or provide a nomination for appointment. The Committee further reviewed the Speaker of the Florida House of Representatives *Sunrise Report,* which addresses many areas of governmental involvement in the health field. The committee intends to closely observe the activities of the Speaker's Advisory Committee and make such recommendations as may be appropriate to the FMA representatives on the Speaker's Advisory Committee, which include Richard S. Hodes, M.D., who served as Chairman of the Speaker's Advisory Committee Subcommittee on Health and Human Resources.

Committee on Health Care Financing and Alternative Delivery Mechanisms

William J. Garoni Jr., M.D., served as Chairman of the Committee on Health Care Financing and Alternative Delivery Mechanisms. The Committee also functioned as the FMA Technical Assistance Panel. At the Committee's first meeting on November 18, 1986, the Committee recommended that the FMA assess the need and feasibility of a proposed survey of physician charges by specialty to be conducted by the Hospital Cost Containment Board's Office of Technical Assistance. The Committee heard a presentation from Blue Cross and Blue Shield of Florida, Inc., pertaining to Medicare competitive medical plans, and recommended that information on this presentation be made available to county medical societies. Further, the Committee asked that the FMA periodically update the data on prepaid plans as contained in the "Feasibility Study of the Florida Medical Association Seeking to Establish a Statewide Prepaid Health Plan."

The Committee also met on April 23, 1987, at which time it heard a presentation by a representive of the Department of Health and Rehabilitative Services on the status of prepaid Medicaid plans and prospects for the future, given impending legislation providing for Medicaid provider fee increases. The preliminary findings of the FMA contracted survey of uncompensated indigent care were presented by the Director of the Center for Health Policy Research of the University of Florida. The preliminary findings indicated that $268 to $477 million of uncompensated care are provided annually by Florida physicians. The administrator of the Florida Office of Technical Assistance presented a sample of the physician specialty charge survey to be undertaken in the summer of 1987. The Chairman of the Committee on Indigent Care, Charles B. McIntosh, M.D., reported to the committee on the status of indigent care financing proposals under consideration by the Florida Legislature. The Committee also received a status report on the Ad Hoc Committee on Prepaid Plans. It further received information pertaining to Medicare Mandated Assignment; the HMO Quality Assurance Act; Medicare HMOs being considered by the U.S. Congress; and the current status of International Medical Centers, a bankrupt HMO in South Florida.

SUPPLEMENTAL REPORT — COUNCIL ON MEDICAL ECONOMICS
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED AS AMENDED

On August 19, 1987, representatives from the Council on Medical Economics and the Council on Medical Services met with Mr. Timothy J. Norbeck, Executive Director of the Connecticut State Medical Society, for the purpose of discussing how their society responded to the proposed legislation on mandatory assignment.

The Connecticut State Medical Society established a medical courtesy card program designed to help meet the health care needs of the lower income senior citizens. The medical courtesy card will be available to seniors over 65 years of age who earn less than $19,950 individually or $24,000 as a family. The medical courtesy card program was offered to all private practice physicians who were encouraged to accept assignment for those senior patients who presented a courtesy card to them. The courtesy card program is designed to reach those seniors who, through pride or fear of embarrassment, avoid discussing financial need with their physicians and, thereby, may forego necessary medical treatment. Applications are submitted to senior citizens and reviewed by the state medical society in accordance with the established eligibility requirements. The program is intended to increase Medicare assignment for those seniors most in need and does not discourage physicians from accepting assignment for elderly patients without a courtesy card on a case by case basis. Participation in the courtesy card program does not, unfortunately, relieve physicians from their responsibility to bill patients for 20 percent co-insurance charge.

As a result of the proposed courtesy card program and introduced by the state medical society, the Connecticut State Legislature did not pass a mandatory Medicare assignment bill. The new Medicare assignment law is, however, based on voluntary acceptance by the majority of the state's physicians. Under the plan, mandatory assignment for Medicare beneficiaries with annual incomes of no more than $19,950 and $24,000 for couples would take effect on July 1, 1988, if the following voluntary conditions have not been met:

1. 85 percent of all practitioners within each of the state's 8 counties must agree to accept Medicare assignments full payment for those covered by the income caps.

2. 80 percent of all specialists must agree to the assignment.

3. At least 50,000 of the state's Medicare beneficiaries must be included in the program.

4. 85 percent of all Medicare claims must come from physicians who accept Medicare assignment.

The only thing that prevented a law tying mandatory assignment to licensure in Connecticut was the courtesy card program. Over 70 percent of Connecticut's physicians already do accept assignment.

Three states, to date, have enacted some type of mandatory assignment legislation — Massachusetts, Vermont and Connecticut. Over 10 states last year considered mandatory assignment bills in their Legislatures. It is anticipated during the 1988 session that as many as 15 to 20 states will be considering some type of mandatory assignment legislation.

The Florida Medical Association was successful during the 1987 session in defeating the proposed Medicare mandatory assignment bill which would tie assignment to licensure. It is anticipated that this bill will resurface during the 1988 session and will have a strong chance of passage.

As a result of hearing the presentation from the Connecticut State Medical Society as well as reviewing the various states initiatives with regards to proposing some type of alternative to mandatory assignment, a recommendation was passed that asked that the FMA enter into some type of courtesy card program as an alternative to avoiding mandatory Medicare assignment.

The Florida Medical Association staff has been in regular contact with representatives of the AARP and other senior citizen organizations. It is the opinion of the FMA that they are still in full support of mandatory assignment but are willing to listen to some type of alternative as a mechanism to address their availability and affordability concerns.

RECOMMENDATION
(Reference Committee No. V, page 1071)

HOUSE ACTION: REFERRED TO BOARD OF GOVERNORS

THAT THE FMA BOARD OF GOVERNORS REAFFIRM ITS OPPOSITION TO MEDICARE MANDATORY ASSIGNMENT AND DEVELOP A COURTESY CARD PROGRAM SIMILAR TO THE ONE ENACTED BY THE CONNECTICUT STATE MEDICAL SOCIETY AS AN ALTERNATIVE TO MANDATED MEDICARE ASSIGNMENT.

RELATIVE VALUE STUDIES

The Council on Relative Value Studies recognizes the amount of staff time needed to update the Florida Relative Value Studies and updating this publication would require that additional resources be made available to publish the Florida Relative Value Studies on an annual basis.

RECOMMENDATION
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED AS AMENDED

THAT THE FMA ANNUALLY UPDATE THE FLORIDA RELATIVE VALUE STUDIES TO INCORPORATE THE MOST CURRENT CPT CODING AND NOMENCLATURE CHANGES AS WELL AS THE NEW DATA AS IT BECOMES AVAILABLE.

COUNCIL ON HOSPITAL MEDICAL STAFFS

Thomas M. Daniel, M.D., Chairman
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED

The Council on Hospital Medical Staffs met twice during the Association year: May 10, 1986, and January 20, 1987. A statewide meeting was held in conjunction with the FMA Leadership Conference on January 20, 1987. The Council addressed many important issues during the Association year including the problems encountered with Medicare reimbursement, PRO denials of hospital admissions, competition in the health care industry and its effect on hospital medical staffs, and JCAH guidelines concerning the quality of care rendered in hospital settings. In addition, the Council conducted several presentations throughout the state to county medical societies and hospital medical staffs regarding the activities of the Council and in collecting up-to-date information on problems the membership have encountered.

At the FMA Annual Meeting in September, 1986, the Council was requested to recommend that the FMA develop model bylaws for hospital medical staffs. In some cases, hospital boards are imposing bylaws on medical staffs by using models developed by hospital attorneys that are unfavorable to physicians. The Council recognized that model bylaws can only be used as a guide for each individual hospital medical staff. The Council felt that the development of model bylaws would be of assistance to hospital medical staffs. Currently, FMA Legal Counsel is in the process of drafting these model bylaws for the Council's review and approval. Other state medical associations, including the California Medical Association, have developed model medical staff bylaws to serve in assisting hospital medical staffs in drafting their bylaws. The Council also recognized that the members of the medical executive committee of a hospital medical staff are responsible to act on behalf of the medical staff. In the event a physician's relationship or affiliation may result in a conflict of interest, then they should not seek such an office. The Council strongly recommended that the FMA adopt this as policy and to communicate this policy to hospital medical staffs and to the Florida Hospital Association, Inc.

Representatives from the Council on Hospital Medical Staffs also worked in concert with the members of the Council on Medical Economics to develop proposed legislation for the delivery and financing of indigent health care in Florida. The Council intensely studied the changing role of hospital medical staffs and the continued development of prepaid plans and their effect on hospitals.

The Council recognizes the continued effect the government will have on the financing of health care. Physicians' input and guidance will be needed in order to ensure that the changes that are made protect the quality of care that is given. One of the major priorities of the Council is to study the future impact of Medicare budget reductions and regulations that are expected to occur over the next year.

The Council is again pleased to report that John M. McBryde, President of the Florida Hospital Association, has participated in all the Council meetings held during the Association year. The Council recognizes the importance of establishing and maintaining a good working relationship with the Florida Hospital Association to address issues of common concern.

The Council was also given a presentation on self-governance of the medical staffs by Howard A. Lang, M.D., Chairman of the American Medical Association, Hospital Medical Staff Section. Dr. Lang encouraged other medical staffs around the state to participate in the Council on Hospital Medical Staffs activities and reported that it is in the physician's power to have an organized, effective voice within Florida and the AMA to direct the actions of both the FMA and the AMA to reflect the unique interest and expertise of hospital medical staffs. He emphasized the fact that current trends are undermining the power of hospital medical staffs and it is essential that physicians become more involved in addressing resolutions to problems that are being encountered. Dr. Lang stated that self-governance, contrary to what many may hear from other sides of the issue, is not being an adversary of hospitals. He emphasized that it is being an advocate for patients and for physicians. Under the new reimbursement systems, the fewer the services to the patient, the better it is to the bottom line for the hospital.

Incentives of the physician and incentives of the patient are unchanged. The financial viability of the hospital is secondary to physicians' roles as patient advocates. Dr. Lang stated that the mission of the medical staff is to provide quality medical care. The economic responsibility of the hospital board may,

at times, come in conflict with patient care responsibility. It is where these missions collide that the medical staff must be in a position to maintain its patient advocacy role and must be in a position to take action in the patient's best interest. Dr. Lang also stated that there are many definitions of self-governance. It can be defined as either a ruling by right of authority, selection of officers, and structure of the medical staff by members of the medical staff, protection against imposition of officers in the structure of the medical staff by hospital management, protection against the imposition of new medical staff bylaws against the wishes of the medical staff, and the amendatory process specifying the medical staff bylaws. The hospital medical staff is professionally independent in exercising medical judgment and shall remain free from any interference influenced by consideration that may conflict with optimum patient care. The governing body cannot delegate but rather authorizes or requires the functioning of the medical staff. The relationship between the governing board, the administration and the medical staff is not a superior/subordinate one, but one of interdependence, mutual accountability, and mutual surveillance. A medical staff is a legally separate entity, an unincorporated association representing the collective professional responsibilities of its individual members in the management of the administration of medical care within the hospital. Dr. Lang emphasized the importance of a medical staff having access to independent legal counsel. If a medical staff is self-governing, it will benefit the community, the hospital it serves, the hospital board, the patients, and the physicians.

The Council also studied problems brought to their attention regarding the Professional Foundation for Health Care, the statewide PRO. During the Council deliberations, a presentation was given by Arthur L. Eberly, M.D., Chairman of the FMA Committee on Professional Review Organizations, with regard to mechanisms of submitting problems that physicians have encountered with admission denials to the Florida Medical Association and how they are addressed and resolved by the Committee. Dr. Eberly encouraged hospital medical staffs to submit individual problems that they have encountered through the Council on Hospital Medical Staffs for their review and study. The information developed by the Council would, ultimately, be conveyed to the Professional Foundation for Health Care in an effort to resolve the problems identified.

In addition, the Council studied some of the current regulations pertaining to sanction activity and strongly recommended that the FMA monitor the sanctions that are being issued to physicians and try to offer any assistance as needed when a sanction is in the process of being considered. Dr. Eberly also reviewed with the Council the methodology used by the PRO in determining whether to deny an admission.

The Council is continuing to work with the Florida Physicians Insurance Company with regard to assisting physicians in minimizing the malpractice exposure in the hospital environment. To date, over 20 risk management seminars have been conducted with over 2500 attendees. The following list is a summary of risk management seminars that have been conducted around the state as well as the additional seminars planned to date:

May 31, 1986	Dade County Medical Association and Broward County Medical Association
June 28, 1986	Florida Academy of Family Physicians
Sept. 18, 1986	FMA Annual Meeting
October 11, 1986	Humana Hospital, Brandon
October 12, 1986	Pasco County Medical Society
October 24, 1986	Florida Academy of Family Physicians
November 1, 1986	Charlotte County Medical Society
November 15, 1986	Brevard County Medical Society
December 13, 1986	Hernando County Medical Society
January 10, 1987	Bay County Medical Society
February 25, 1987	Pinellas County Medical Society
February 26, 1987	Pinellas County Medical Society
February 26, 1987	Space Coast Institute
March 4, 1987	Clay County Medical Society
March 12, 1987	Alachua County Medical Society
March 20, 1987	FMA Leadership Conference
April 8, 1987	Palm Beach County Medical Society
April 25, 1987	Seminole County Medical Society
May 2, 1987	Indian River County Medical Society
May 16, 1987	Manatee County Medical Society
June 10, 1987	Florida Academy of Family Physicians
October 24, 1987	Duval County Medical Society



FMA Officers at the House of Delegates (left to right): Mr. Donald C. Jones, Jacksonville, Executive Vice President; James B. Perry, M.D., Ft. Lauderdale, President; Guy T. Selander, M.D., Jacksonville, Speaker of the House; Standing: Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker; James G. White, M.D., Ormond Beach, President-Elect; Kay K. Hanley, M.D., Clearwater, Vice President; Henry M. Yonge, M.D., Pensacola, Secretary; and Yank D. Coble Jr., M.D., Jacksonville, Treasurer.



The annual Past Presidents Breakfast is always a highlight. Seated (left to right): James T. Cook Jr., M.D., Marianna (1970); Henry J. Babers Jr., M.D., Gainesville (1969); Jere W. Annis, M.D., Lakeland (1958); W. Dean Steward, M.D., Orlando (1967); Thad Moseley, M.D., Jacksonville (1974); Joseph C. Von Thron, M.D, Cocoa Beach (1973); George S. Palmer, M.D., Tallahassee (1986). Standing: O. William Davenport, M.D., Miami (1978); William J. Dean, M.D., St. Petersburg (1972); Edward Annis, M.D., Miami, AMA Past President; H. Phillip Hampton, M.D., Tampa (1965); Louis C. Murrary, M.D., Orlando (1977); T. Byron Thames, M.D., Orlando (1980); Frank C. Coleman, M.D., Tampa (1984); Sanford A. Mullen, M.D., Jacksonville (1981); Richard S. Hodes, M.D., Tampa (1979).

RESOLUTIONS

No. 1 PRO PROVISIONS
Introduced by Lee County Medical Society
(Reference Committee No. V, page 1071)

HOUSE ACTION: SUBSTITUTE RESOLUTION 1 WAS ADOPTED IN LIEU OF RESOLUTIONS 1, 3, AND 5

RESOLVED, That the Florida Medical Association and the American Medical Association seek legislation to significantly revise the professional review organization statutes as now written and implemented through HCFA guidelines to reflect the community standards for quality of care.

No. 2 CONSTITUTIONAL AMENDMENTS
Introduced by Lee County Medical Society
(Reference Committee No. III, page 1062)

HOUSE ACTION: SUBSTITUTE RESOLUTION 2 WAS ADOPTED

RESOLVED, That the Florida Medical Association undertake an initiative to have placed on the ballot a constitutional amendment to limit awards in all liability cases to $100,000 for noneconomic damages; and be it further

RESOLVED, That the FMA assess its members $500 to support legislative and constitutional tort reform, and the Board of Governors decide at what date this becomes necessary and mandatory, and be it further

RESOLVED, That financing for these undertakings also be sought from other interested parties, such as the members of the Coalition for Tort Reform.

RESOLVED, That the assessment not be levied until the Supreme Court rules that our constitutional amendment has been properly worded.

No. 3 PRO PROVISIONS
Introduced by Panhandle Medical Society
(Reference Committee No. V, page 1071)

RESOLUTION 3 WAS CONSIDERED TOGETHER WITH RESOLUTIONS 1 AND 5.

No. 4 PAPERWORK REDUCTION
Introduced by Sarasota County Medical Society
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the Florida Medical Association determine through appropriate mechanisms the types and diversity of forms and reports which are now being requested of physicians and develop techniques, methods and uniform standards for reports which would decrease the number and complexity of reports and decrease the liability for the physician when such reports are submitted.

No. 5 PRO PROVISIONS
Introduced by Sarasota County Medical Society, Capital Medical Society, Dade County Medical Association, Lake County Medical Society and Manatee County Medical Society
(Reference Committee No. V, page 1071)

RESOLUTION 5 WAS CONSIDERED TOGETHER WITH RESOLUTIONS 1 and 3.

No. 6 FMA GRIEVANCE PROCEDURES
Introduced by Lee County Medical Society
(Reference Committee No. III, page 1062)

HOUSE ACTION: REFERRED TO BOARD OF GOVERNORS

RESOLVED, That the Florida Medical Association immediately rescind the statewide grievance procedures and policies and return grievance policy to the county level.

No. 7 MECHANISM FOR POLLING FMA MEMBERS
Introduced by Hillsborough County Medical Association
(Reference Committee No. III, page 1062)

HOUSE ACTION: REFERRED TO BOARD OF GOVERNORS

RESOLVED, That the Florida Medical Association adopt a mechanism of polling its members, including but not limited to a poll at the meetings of the House of Delegates.

No. 8 FMA LONG-RANGE PLANNING COMMITTEE
Introduced by Hillsborough County Medical Association
(Reference Committee No. III, page 1062)

HOUSE ACTION: SUBSTITUTE RESOLUTION 8 WAS ADOPTED

RESOLVED, That the Board of Governors appoint an Ad Hoc Committee to the Executive Committee (Long-Range Planning Committee) with appropriate grassroots representation to provide advice to the Executive Committee for long-range planning.

No. 9 FMA PROFESSIONAL LIABILITY COMMITTEE
Introduced by Hillsborough County Medical Association
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the Board of Governors maintain an Ad Hoc Committee on Professional Liability for an indefinite time and that the Committee have adequate representation from high and low risk specialties.

No. 10 INDIVIDUAL RISK MANAGEMENT
Introduced by Hillsborough County Medical Association
(Reference Committee No. II, page 1059)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the FMA House of Delegates support the right of physicians to individual risk management, including the right to select which patients will be seen on an emergency basis, when the physician's particular circumstances dictate the necessity during the Florida liability crisis; that official representatives of the Florida Medical Association espouse this right in their public utterances, when appropriate.

No. 11 CIGARETTE SALE TO MINORS STATUTE
Introduced by Hillsborough County Medical Association
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the Florida Medical Association encourage the Florida Legislature to amend Chapter 859.06, Florida Statutes, to strengthen appropriate penalties for sale and possession and that the FMA encourage compliance with the statute through a cooperative program with corporations and associations of grocery stores, drug stores, convenience stores and vending machines; and that the FMA and its Auxiliary develop a comprehensive educational campaign to warn youths and their parents of the long-range health risks and of the economic and social disadvantages of starting smoking.

No. 12 REPEAL OF FIVE-HOUR CME RISK MANAGEMENT RULE
Introduced by Hillsborough County Medical Association
(Reference Committee No. IV, page 1068)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the legal requirement for mandatory risk management be repealed.

No. 13 REINSTATEMENT OF FMA MEMBERSHIP
Introduced by Orange County Medical Society
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED AND REFERRED TO THE COMMITTEE ON BYLAWS FOR REVIEW AND IMPLEMENTATION.

RESOLVED, That the Board of Governors be directed to develop a membership policy to require that former FMA members applying for membership in a different Florida county medical society be required to be a member in good financial standing in their previous county medical society before the FMA will permit them to reinstate their membership in the FMA and join the different county medical society.

No. 14 FMA MEMBERSHIP DEVELOPMENT FINANCING FOR COUNTY MEDICAL SOCIETIES
Introduced by Orange County Medical Society
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

RESOLVED, That the Board of Governors be directed to establish a membership development financing program that would rebate 15% of each new FMA member's first year FMA dues back to the appropriate county medical society to help underwrite the cost of its membership development program.

No. 15 CONSENT FOR EMERGENCY RESOLUTIONS
Introduced by Orange County Medical Society
(Reference Committee No. III, page 1062)

HOUSE ACTION: REFERRED TO BOARD OF GOVERNORS

RESOLVED, That delegates presenting resolutions for emergency consideration by the House explain briefly the reasons the resolution should be considered an emergent resolution; and be it further

RESOLVED, That if there is only a single vote in opposition to consideration of an emergency resolution, the person casting that vote must identify himself or herself as a voting delegate by stating his or her name and county in order for the objection to be valid.

No. 16 FLAG CEREMONY
Introduced by Orange County Medical Society
(Reference Committee No. III, page 1062)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the Board of Governors be directed to develop a flag ceremony to be used in conjunction with the opening of the annual House of Delegates meetings; and be it further

RESOLVED, That the FMA order flags to be used in the Flag ceremony representing each medical society. Such flags will be of uniform size and will display the logo and colors of each society.

No. 17 AIDS TESTING
Introduced by Dade County Medical Association
(Reference Committee No. II, page 1059)

HOUSE ACTION: REFERRED TO BOARD OF GOVERNORS FOR STUDY AND CONSIDERATION BY THE FMA AD HOC COMMITTEE ON AIDS

RESOLVED, That the Florida Medical Association, in accordance with recent actions of the American Medical Association, should implement the guidelines for appropriate and uniform testing as recommended by the AMA, as follows:

1. Tests for the AIDS virus should be readily available to all who wish to be tested. The tests should be routinely subsidized for individuals who cannot afford to pay the cost of their test.

2. Testing for the AIDS virus should be mandatory for donors of blood and blood fractions, organs and other tissues intended for transplantation in the U.S. or abroad, for donors of semen or ova collected for artificial insemination or in vitro fertilization, for all immigrants to the U.S., for all inmates of federal and state prisons and for all military personnel.

3. Testing for the AIDS virus should be mandatory for all hospital admissions and ambulatory surgical patients.

4. Voluntary testing should be regularly provided for the following types of individuals who give an informed consent:

 a. Patients at sexually transmitted disease clinics.
 b. Patients at drug abuse clinics.
 c. Pregnant women in high risk areas in the first trimester of pregnancy.
 d. Individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior seeking family planning services.
 e. Patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures. If the voluntary policy is not sufficiently accepted, the hospital and medical staff should consider a mandatory program for the institution.

5. As a matter of medical judgment, physicians should encourage voluntary HIV testing for individuals whose history or clinical status warrant this measure.

6. Individuals who are found to be seropositive for the AIDS virus should be reported to appropriate public health officials on an anonymous or confidential basis with enough information to be epidemiologically significant.

7. Physicians should counsel patients before tests for AIDS to educate them about effective behaviors to avoid the risk of AIDS for themselves and others. In public screening programs, counseling may be done in whatever form is appropriate given the resources and personnel available as long as effective counseling is provided.

8. Physicians should counsel their patients who are found to be seropositive regarding (a) responsible behavior to prevent the spread of the disease, (b) strategies for health protection with a compromised immune system, (c) the necessity of alerting sexual contacts, past (5-10 years) and present, regarding their possible infection by the AIDS virus. Long-term emotional support should be provided or arranged for seropositive individuals.

9. Patients should knowingly and willingly give consent before a voluntary test is conducted.

No. 18 AIDS EDUCATIONAL PROGRAM
Introduced by Dade County Medical Association
(Reference Committee No. II, page 1059)

HOUSE ACTION: REFERRED TO BOARD OF GOVERNORS FOR STUDY AND CONSIDERATION BY THE FMA AD HOC COMMITTEE ON AIDS

RESOLVED, That the Florida Medical Association initiate and participate in the immediate development and implementation of an AIDS educational program for Florida residents, including a comprehensive inservice program for physicians.

No. 19 SCHOOL-BASED HEALTH CLINICS
Introduced by Dade County Medical Association
(Reference Committee No. II, page 1059)

HOUSE ACTION: ADOPTED

RESOLVED, That the Florida Medical Association endorse the concept of school-based clinics in communities where they are desired by the parents; and be it further

RESOLVED, That the Florida Medical Association urge Governor Martinez to reverse his decision and allow Dade County to go forward with their planned school-based clinic for the health of our children, and be it further

RESOLVED, That should Governor Martinez not reverse his decision, the FMA immediately seek alternative ways of assisting in organizing and coordinating the establishment of school-based clinics in communities where they are desired by the parents, through private means.

No. 20 BLOOD ALCOHOL LEVEL — STATE LEGISLATION
Introduced by Dade County Medical Association
(Reference Committee No. II, page 1059)

HOUSE ACTION: ADOPTED

RESOLVED, That the Florida Medical Association, in accordance with actions taken by the American Medical Association, petition the State Legislature for the enactment of legislation calling for a maximum 0.05 percent blood alcohol level standard for operators of motor vehicles as prima facie evidence of a violation of driving under the influence (DUI) laws.

No. 21 ALL-TERRAIN VEHICLE SAFETY
Introduced by Dade County Medical Association
(Reference Committee No. II, page 1059)

HOUSE ACTION: SUBSTITUTE RESOLUTION 21 WAS ADOPTED

RESOLVED, That the Florida Medical Association, in accordance with actions taken by the American Medical Association at its June 1987 Annual Meeting, develop and incorporate into its 1988 Legislative program to:

1. Prohibit the use of all-terrain vehicles (ATV) for children under age 16 on all public lands;
2. Mandate helmets for ATV drivers and riders;
3. Punish drivers operating ATV under the influence of alcohol or controlled substances in the same manner as if they were driving on-road vehicles; and
4. Establish a system of reporting ATV-related injuries.

No. 22 REVIEW OF MEDICAL RECORDS BY GOVERNMENTAL AND INSURANCE AGENCIES
Introduced by Dade County Medical Association
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

RESOLVED, That in accordance with actions taken by the American Medical Association at its June 1987 Annual Meeting, the FMA support the concept that when a third party (insurance or governmental) seeks access to a patient's office medical file, that any access granted be limited to the specific illness or incident being questioned; and be it further

RESOLVED, That any access to a patient's medical file should be granted only with patient's specific consent; and be it further

RESOLVED, That the Florida Medical Association, in accordance with actions taken by the American

Medical Association, encourage physicians to help their patients understand the serious confidential issues involved in third party access to medical records, including patient rights under the law.

No. 23 SUPPORT FOR MEDICAL MALPRACTICE DEFENDANTS
Introduced by Dade County Medical Association
(Reference Committee No. I, page 1057)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the FMA actively engage in developing a plan to make emotional support for medical malpractice defendants available to its members.

No. 24 SUBSTITUTION OF GENERIC DRUGS
Introduced by Dade County Medical Association
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the FMA support legislation to amend the law to require that the pharmacist fill the prescription as written unless the physician checks off a box indicating that substitution is allowed.

No. 25 DISPENSING BY PHYSICIANS
Introduced by Dade County Medical Association
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

RESOLVED, That the Florida Medical Association, in accordance with recent actions of the AMA, support legislation to maintain the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA's ethical guidelines.

No. 26 PAYMENT FOR PHYSICIANS' SERVICES
Introduced by Dade County Medical Association
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the Florida Medical Association, in accordance with recent actions of the American Medical Association, reaffirm the physician's obligation to compassionately consider the patient's ability to pay in setting a fee; and be it further

RESOLVED, That the Florida Medical Association, in accordance with recent actions of the American Medical Association, reaffirm the physician's right to set a fair fee for services and to contract directly with the patient for provision of those services; and be it further

RESOLVED, That the Florida Medical Association, in accordance with the American Medical Association, reaffirm to the public the principle that payment schedules adopted by third party payors shall be construed as schedules of benefits to their covered insureds except in cases where physicians have voluntarily contracted with the insurer to accept those benefits as payment in full for services rendered.

No. 27 RELOCATION OF FMA ANNUAL MEETINGS
Introduced by Dade County Medical Association
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the Florida Medical Association, when economically feasible, arrange for future FMA annual meetings to be conducted in another facility.

No. 28 CANDIDATES FOR STATE ELECTIONS
Introduced by Manatee County Medical Society
(Reference Committee No. III, page 1062)

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the Manatee County Medical Society and its parent organization, the Florida Medical Association, undertake the program of public education designed to urge all eligible citizens of Florida to vote for non-attorney candidates in state elections until such time as these recalcitrant issues have been effectively addressed and remedied.

No. 29 CONTINUING MEDICAL EDUCATION
Introduced by Sarasota County Medical Society
(Reference Committee No. I, page 1057)

HOUSE ACTION: SUBSTITUTE RESOLUTION 29 WAS ADOPTED IN LIEU OF RESOLUTION AND RECOMMENDATION A-1 (REPORT A OF THE BOARD OF GOVERNORS — SEE PAGE 000).

RESOLVED, That the FMA reaffirms its commitment to contiuing medical education as a requirement for FMA membership; that FMA members must meet the State of Florida CME requirements; and that reporting be limited to requirements of State of Florida law.

No. 30 PHYSICIAN ADVOCACY FOR INDIGENT CARE
Introduced by Hillsborough County Medical Association
(Reference Committee No. IV, page 1068)

HOUSE ACTION: REFERRED TO THE BOARD OF GOVERNORS

RESOLVED, That the Florida Medical Association requests the Legislature of the State of Florida to re-enact legislation to require the establishment of a state/county matching fund to pay costs for health care for indigents not eligible for existing programs.

No. 31 SALES TAX ON MEDICAL COLLECTION
Introduced by Collier County Medical Society
(Reference Committee No. IV, page 1068)

HOUSE ACTION: REFERRED TO BOARD OF GOVERNORS

RESOLVED, That the Florida Medical Association seek clarification from the Florida Department of Revenue regarding collection agencies charging a 5% service tax on their fees when such fees are generated by tax exempt medical services; and be it further

RESOLVED, That if the Florida Department of Revenue mandates the levying of a 5% service tax on collection agency fees which arise from statutory-exempt medical care, the FMA use its resources to repeal this levy.

No. 32 PROFESSIONAL FOUNDATION FOR HEALTH CARE
Introduced by Captial Medical Society
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

RESOLVED, That the Capital Medical Society requests that the Florida Medical Association support the lawsuit filed on Dr. Dozier's behalf and the other physicians of the State of Florida against the Professional Foundation for Health Care for denial of due process; and further for the Florida Medical Association to request support from the American Medical Association.

No. 33 FLAMEDCO, INC., POLICIES
Introduced by Collier County Medical Society
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the FMA direct FLAMEDCO, Inc., to improve upon appropriate monitoring procedures to assure FMA membership is receiving fair, prompt and just service by reporting to the FMA Board annually on application performance. FMA Board approval should continue to be required for all insurance application protocols and should not deviate from industry standards for such matters as physical exam requirements, medical diagnostic testing requirements particularly for such items as stress tests and AIDS blood tests. If Manhattan Life Insurance Company application policies are at variance with industry standards the contractual arrangement with Manhattan Life Insurance Company and FLAMEDCO, Inc., should be terminated.

No. 34 TAX DEDUCTIBILITY OF STUDENT LOAN INTEREST
Introduced by Medical Student Section Governing Council
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the Florida Medical Association support full tax deductibility for student loan interest; and be it further

RESOLVED, That the FMA urge members of Florida's congressional delegation to sponsor and support appropriate amendments to the 1986 Federal Tax Reform Act that would restore such deductibility; and be it further

RESOLVED, That the full cooperation of the American Medical Association be enlisted in this undertaking.

No. 35 INFECTIOUS MEDICAL WASTE
Introduced by Dade County Medical Association
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED

RESOLVED, That the FMA urges that the AMA promote the passage of Federal Legislation with regard to proper disposal of infectious medical waste products.

No. 36 EXPERT WITNESS
Introduced by Brevard County Medical Society
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the Florida Medical Association, in its 1988 legislative program, seek legislation that requires an expert witness giving testimony in court or by deposition be licensed and actively practicing medicine in Florida, have practiced in the specialty about which he will be testifying for at least the past four years; and be it further

RESOLVED, That the Florida Medical Association also seek legislation requiring that the plaintiff's attorney obtain a written opinion from an expert witness so qualified that a cause of action exists, prior to filing a claim.

No. 37 LIABILITY INSURANCE PREMIUMS
Introduced by Broward County Medical Association
(Reference Committee No. III, page 1062)

HOUSE ACTION: REFERRED TO BOARD OF GOVERNORS

RESOLVED, That the Florida Medical Association assume a strong leadership position in efforts to eliminate this multi-tiered system in pricing liability insurance premiums for the physicians in the State of Florida.

No. 38 MANDATORY INSURANCE FOR LICENSURE
Introduced by Broward County Medical Association
(Reference Committee No. III, page 1062)

HOUSE ACTION: ADOPTED

RESOLVED, That the Florida Medical Association reaffirm its policy that mandatory insurance coverage to obtain license is contrary to the health of the citizens of Florida, and that every effort will be utilized to combat legislation that would seek this end.

No. 39 LAWSUIT AGAINST PRO
Introduced by Polk County Medical Association
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the Board of Governors of the Florida Medical Association consider joining the September 3, 1987, lawsuit filed by over fifty Florida hospitals against the Health Care Financing Administration.

No. 40 ALLIED HEALTH CARE PRACTITIONERS
Introduced by Broward County Medical Association
(Reference Committee No. IV, page 1068)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the House of Delegates will continue to combat the prescription of diagnostic or therapeutic drugs by allied health care practitioners not licensed under Chapters 458, 459 and 466, Florida Statutes, through legislative action; and be it further

RESOLVED, That privilege in acute care facilities continues to be a matter of medical staff determination, with Governing Board approval; and be it further

RESOLVED, That the FMA continue to protest the attempted incursion of allied health care practitioners into the unlimited practice of medicine and surgery which tends to decrease the quality of health care.

No. 41 MEDICARE REIMBURSEMENT SCHEDULES
Introduced by Broward County Medical Association
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That Maximum Actual Allowable Charges (MAAC) appear to be a dual fee schedule which unfairly discriminates against a large number of physicians; and be it further

RESOLVED, That the FMA rebuff efforts by commercial carriers or governmental agencies that would require physicians to predict reimbursement for services rendered.

No. 42 MEDICARE
Introduced by Sarasota County Medical Society
(Reference Committee No. V, page 1071)

HOUSE ACTION: ADOPTED AS AMENDED

RESOLVED, That the FMA President and Board of Governors immediately send a telegram to President Ronald Reagan indicating our extreme displeasure with governmental misinformation which is

abusive and discriminatory toward physicians and indicts them as the single cause for Medicare cost overruns; and be it further

RESOLVED, That a response be requested as to how such misinformation is released to the media; and be it further

RESOLVED, That a copy of this entire resolution be forwarded to all members of the Florida Congressional Delegation; and be it further

RESOLVED, That the AMA be informed of Florida's actions.

EMERGENCY RESOLUTION — MEMBERSHIP RALLY IN TALLAHASSEE
Introduced by Dade and Hillsborough County Medical Associations
(Submitted on Floor of the House)

HOUSE ACTION: ADOPTED

RESOLVED, That the Florida Medical Association make plans for a membership rally in Tallahassee at the time of the special session, and while doing so, the Florida Medical Association stress to the medical staffs the importance of planning to maintain emergency medical services during the rally.

ELECTIONS

PRESIDENT-ELECT: Yank D. Coble Jr., M.D.
VICE PRESIDENT: Kay K. Hanley, M.D.
SPEAKER OF THE HOUSE: Guy T. Selander, M.D.
VICE SPEAKER OF THE HOUSE: Arthur L. Eberly, M.D.
SECRETARY: Henry M. Yonge, M.D.
TREASURER: Dick L. Van Eldik, M.D.

BOARD OF GOVERNORS — DISTRICT B: Calvin Martin, M.D.

AMERICAN MEDICAL ASSOCIATION DELEGATES AND ALTERNATE DELEGATES

(Term: January 1, 1988 — December 31, 1989)

DELEGATE SEAT #1	T. Byron Thames, M.D.
ALTERNATE	Daniel L. Seckinger, M.D.
DELEGATE SEAT #4	Frank C. Coleman, M.D.
ALTERNATE	Eugene G. Peek Jr., M.D.
DELEGATE SEAT #6	Charles J. Kahn, M.D.
ALTERNATE	O. William Davenport, M.D.
DELEGATE SEAT #7	Joseph C. Von Thron, M.D.
ALTERNATE	Charles A. Dunn, M.D.
DELEGATE SEAT #8	Louis C. Murray, M.D.
ALTERNATE	Alvin E. Smith, M.D.
DELEGATE SEAT #12	J. Lee Dockery, M.D.
ALTERNATE	A. Frederick Schild, M.D.

COMMITTEE ON MEMBERSHIP AND DISCIPLINE

District	Nominees	District	Nominees
1	James T. Cook III, M.D. (91)	11	David Tingle, M.D. (91)
2	Robert P. Johnson, M.D. (91)	12	V.A. Marks, M.D. (91)
3	Hugh A. Carithers, M.D. (91)	13	Richard C. Rehmeyer, M.D. (91)
4	Craig Raby, M.D. (91)	14	Lee A. Fischer, M.D. (91)
5	Frederick Weigand, M.D. (91)	15	Stanley S. Goodman, M.D. (91)
6	Michael J. Lukowski, M.D. (91)	16	William C. Hartley, M.D. (91)
7	Linus W. Hewit, M.D. (91)	17	Alan S. Graubert, M.D. (91)
8	William E. Hale, M.D. (91)	18	Everett Shocket, M.D. (91)
9	David B. Johnson, M.D. (91)	19	John D. White, M.D. (91)
10	William Allen Boyce, M.D. (91)		

Reference Committee No. I
Health and Education



Reference Committee No. I (Health and Education) was chaired by Alvin E. Smith, M.D., Ormond Beach. Left to right: Richard L. Glatzer, M.D., Miami; Randall D. Bertolette, M.D., Vero Beach; Recorder Mrs. Diane Bowker; Dr. Smith, Standing; Larry P. Garrett, M.D., Fort Myers; Herbert E. Brooks, M.D., Bonifay.

Reference Committee No. II
Public Policy



Reference Committee No. II (Public Policy) was chaired by Joseph E. Holland, M.D., Leesburg. Left to right: Harold G. Norman, M.D., Miami; Gilbert R. Panzer, M.D., Boynton Beach; Recorder Mrs. Lisa Van Dalen; Standing: Dr. Holland; David A. D'Allesandro, M.D., Lighthouse Point; C. Davis Whelchel III, M.D., Jacksonville.

Reference Committee No. III
Finance and Administration



Reference Committee No. III (Finance and Administration) was chaired by Bruce W. Weissman, M.D., Miami. Left to right: Frank C. Coleman, M.D., Tampa, AMA Delegate Advisor; Paul T. Baroco, M.D., Pensacola; Recorder Ms. Lynn Moborak; Standing: Dr. Weissman; Harold L. Ishler Jr., M.D., Clearwater; Miguel R. Alonso, M.D., Tampa; John B. Adamson, M.D., Cocoa Beach.

Reference Committee No. IV
Legislation and Miscellaneous



Reference Committee No. IV (Legislation and Miscellaneous) was chaired by Juan S. A. Wester, M.D., Ft. Lauderdale. Left to right: Recorder Mrs. Helen Bradford; David L. Thomas, M.D., Venice; Standing: Dr. Wester; Gaston J. Acosta-Rua, M.D., Jacksonville; Julian H. Groff, M.D., Miami Beach; James A. Gordon, M.D., Ft. Lauderdale.

Reference Committee No. V
Medical Economics



Reference Committee No. V (Medical Economics) was chaired by Wilbert L. Dawkins Sr., M.D., Jacksonville. Left to right: Cecil B. Wilson, M.D., Winter Park; John E. Perchalski, M.D., Temple Terrace; Recorder Mrs. Betty Daly; Standing: Dr. Dawkins; Sheldon Zane, M.D., Miami Beach; Darrel W. Wyatt, M.D., Orange Park; Charles J. Kahn, M.D., Pensacola, AMA Delegate.

REPORTS OF REFERENCE COMMITTEES AS PRESENTED TO THE HOUSE OF DELEGATES

The following Reports of Reference Committees DO NOT REPRESENT FINAL HOUSE ACTION. The page number at the end of each recommendation refers to final action of the House of Delegates.

I. REFERENCE COMMITTEE ON HEALTH AND EDUCATION

Alvin E. Smith, M.D., Ormond Beach, Chairman
Larry P. Garrett, M.D., Fort Myers
Randall D. Bertolette, M.D., Vero Beach
Richard L. Glatzer, M.D., Miami
Herbert E. Brooks, M.D., Bonifay
Kay K. Hanley, M.D., St. Petersburg, AMA Delegate Advisor

Mr. Speaker, Mr. President and Members of the House of Delegates:

Your Reference Committee No. I — Health and Education — has considered each of the items referred to it and desires to present the following report. The Reference Committee's recommendations on each item will be submitted separately, and I respectfully suggest that each item be acted upon before going on to the next.

(1) REPORT OF THE COUNCIL ON SCIENTIFIC ACTIVITIES

Mr. Speaker, the Reference Committee heard considerable testimony regarding the scientific activities of the Florida Medical Association Annual Meeting. In order to enhance the educational programs of the scientific sessions available to Florida Medical Association members, the committee recommends that an Ad Hoc Committee be appointed to study the possibility of changing the location of the FMA Annual Meeting, increasing the amount of CME study programs available at the meeting, and the possibility of having a separate scientific session at a different time of the year.

MR. SPEAKER, THE REFERENCE COMMITTEE MOVES THAT AN AD HOC COMMITTEE BE APPOINTED TO STUDY THE POSSIBILITY OF CHANGING THE LOCATION OF THE FMA ANNUAL MEETING AND THE POSSIBILITY OF HAVING A SEPARATE SCIENTIFIC SESSION AT A DIFFERENT TIME OF THE YEAR IN ORDER TO INCREASE THE AMOUNT OF CME STUDY PROGRAMS AVAILABLE TO FMA MEMBERS.

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE COUNCIL ON SCIENTIFIC ACTIVITIES BE ADOPTED AS PRESENTED (See page 997).

(2) REPORT OF THE COUNCIL ON SPECIALTY MEDICINE

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE COUNCIL ON SPECIALTY MEDICINE BE ADOPTED AS PRESENTED (See page 998).

(3) SUPPLEMENTAL REPORT OF THE COUNCIL ON SPECIALTY MEDICINE

During the discussion of the Supplemental Report of the Council on Specialty Medicine Report, it was noted that on line 11 the spelling of "Anesthesiologist" should be corrected to read "Anesthesiologists." And also on line 13 the spelling of "Onocologists" should be corrected to read "Oncologists."

It was also noted that the Florida Association of General Surgeons should be inserted after line 25 under Recommendation No. 1 pertaining to specialty groups recommended for approval of continuing recognition.

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT THE SUPPLEMENTAL REPORT OF THE COUNCIL ON SPECIALTY MEDICINE BE ADOPTED AS AMENDED (See page 998).

(Not Final Action of the House)

(4) REPORT A OF THE BOARD OF GOVERNORS

During the discussion of the Board of Governors Report it was noted on page I-5, lines 44-48, that the item entitled "Use of Animals in Medical Research" is a resolution that should be acted upon separately by the House of Delegates. The Reference Committee numbered this Resolution as Recommendation A-5, and recommends the following amendments:

On line 48 correct the spelling of the word "human" to "humane;" on line 80 add "and be it resolved" after the word "research," and on line 82 delete the words "which has always prevailed."

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION A-5 AND THE RESOLUTION ON THE USE OF ANIMALS IN MEDICAL RESEARCH BE ADOPTED AS AMENDED (See page 948)

During the discussion of the Board of Governors Report, it was noted that on page I-6, line 31, that the amount "$41,401.80" should be changed to "$51,401.80"; it was also noted that on line 113 the word "Region" should be corrected to read "Chapter"; line 122 should be corrected to read "did not reapply." On page I-7, line 5, the word "applcation" should be corrected to read "application."

RECOMMENDATION A-1 AND RESOLUTION 87-29 —
CONTINUING MEDICAL EDUCATION — Sarasota County Medical Society

The Reference Committee considered Recommendation A-1 of the Board of Governors Report and Resolution 87-29 together as they both pertain to the same subject. The Reference Committee heard considerable testimony on Recommendation A-1 and offers the following substitute for Resolution 87-29:

"RESOLVED, That the FMA reaffirms its commitment to continuing medical education as a requirement for FMA membership; that FMA members must meet the State of Florida CME requirements; and that reporting be limited to requirements of State of Florida law."

MR. SPEAKER, THE REFERENCE COMMITTEE MOVES THAT THIS AMENDMENT BE ADOPTED.

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE 87-29 BE ADOPTED (See page 1049)

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION A-1 **NOT** BE ADOPTED (See page 948).

RECOMMENDATION A-2

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION A-3 BE ADOPTED AS PRESENTED (See page 948).

RECOMMENDATION A-3

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION A-3 BE ADOPTED AS PRESENTED (See page 948).

RECOMMENDATION A-4

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION A-4 BE ADOPTED AS PRESENTED (See page 948).

(Not Final Action of the House)

Mr. Speaker, the Reference Committee heard testimony on the subject of "Relative Values of Medical Mishaps and Indigent Care," page I-7, lines 35-40, of the Board of Governors Report. The Reference Committee on the basis of this testimony wishes to express concern about the establishment of separate values for indigent care or the assignment of specific charges for any relative values, and that this concern be conveyed to the Council on Specialty Medicine.

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT REPORT A OF THE BOARD OF GOVERNORS BE ADOPTED AS AMENDED (See page 948).

Your Reference Committee would like to express its appreciation to all members of our Association who appeared at our meeting to provide guidance and counsel.

Your Reference Committee would like to express its appreciation to Pierre J. Bouis Jr., M.D., Chairman, Council on Scientific Activities; and to Thomas D. Bartley, M.D., Chairman, Council on Specialty Medicine, with special consideration and thanks to Mrs. Dawn Gerik for her loyal and dedicated assistance throughout the Association year.

Special thanks are conveyed to Kay K. Hanley, M.D., who represented the AMA Delegation at the meeting of this Reference Committee. I would like to take this opportunity to express my sincere appreciation to the members of this Committee: Larry P. Garrett, M.D.; Randall D. Bertolette, M.D.; Richard L. Glatzer, M.D.; and Herbert E. Brooks, M.D.

The Reference Committee would also like to thank FMA staff E. Russell Jackson Jr., M.A., M.P.H., and Mrs. Diane Bowker for their assistance in the preparation of this report.

MR. SPEAKER, I MOVE THAT THE REPORT OF REFERENCE COMMITTEE I BE ADOPTED (AS AMENDED).

Mr. Speaker, this concludes the report of Reference Committee I.

II. REFERENCE COMMITTEE ON PUBLIC POLICY

Joseph E. Holland, M.D., Leesburg, Chairman
C. Davis Whelchel III, M.D., Jacksonville
David A. D'Allesandro, M.D., Lighthouse Point
Harold G. Norman, M.D., Miami
Gilbert R. Panzer, M.D., Boynton Beach
Daniel L. Seckinger Jr., M.D., Miami, AMA Delegate Advisor

Mr. Speaker, Mr. President and Members of the House of Delegates: Your Reference Committee No. II — Public Policy — has considered each of the items referred to it and desires to present the following report. The Reference Committee's recommendations on each item will be submitted separately, and I respectfully suggest that each item be acted upon before going on to the next.

(1) REPORT OF THE COUNCIL ON MEDICAL SERVICES

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THE REPORT OF THE COUNCIL ON MEDICAL SERVICES BE ADOPTED AS PRESENTED (See page 1000)

(2) SUPPLEMENTAL REPORT — COUNCIL ON MEDICAL SERVICES

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THE SUPPLEMENTAL REPORT ON THE COUNCIL ON MEDICAL SERVICES BE ADOPTED AS PRESENTED (See page 1000)

(3) SUPPLEMENTAL REPORT II — COUNCIL ON MEDICAL SERVICES

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THE SUPPLEMENTAL REPORT II OF THE COUNCIL ON MEDICAL SERVICES BE ADOPTED AS PRESENTED (See page 1000)

(Not Final Action of the House)

(4) REPORT B OF THE BOARD OF GOVERNORS

Mr. Speaker, the Reference Committee recommends that the following correction be made to this report:

On page II-7, move lines 19 through 21 to be placed after line 10 on page II-7.

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT THE BOARD OF GOVERNORS REPORT B BE ADOPTED AS CORRECTED (See page 952).

RESOLUTIONS:

RESOLUTION 87-10 — INDIVIDUAL RISK MANAGEMENT,
Hillsborough County Medical Association, Inc.

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-10 **NOT** BE ADOPTED (See page 1044)

RESOLUTION 87-17 — AIDS TESTING,
Dade County Medical Association

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-17 BE REFERRED TO THE BOARD OF GOVERNORS FOR STUDY AND CONSIDERATION BY THE FMA AD HOC COMMITTEE ON AIDS (See page 1045)

RESOLUTION 87-18 — AIDS EDUCATIONAL PROGRAM,
Dade County Medical Association

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-18 BE REFERRED TO THE BOARD OF GOVERNORS FOR STUDY AND CONSIDERATION BY THE FMA AD HOC COMMITTEE ON AIDS (See page 1046)

RESOLUTION 87-19 — SCHOOL BASED HEALTH CLINICS,
Dade County Medical Association

Mr. Speaker, there is a minority report on this subject (See page 1047)

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-19 BE ADOPTED (See page 1047)

RESOLUTION 87-20 — BLOOD ALCOHOL LEVEL — STATE LEGISLATION,
Dade County Medical Association

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-20 BE ADOPTED (See page 1047)

RESOLUTION 87-21 — ALL-TERRAIN VEHICLE SAFETY,
Dade County Medical Association

Mr. Speaker, the Reference Committee recommends that the following change be made to this Resolution:

Please change lines 20 through 23 to read: "RESOLVED, That the Florida Medical Association, in accordance with actions taken by the American Medical Association at its June 1987 Annual Meeting, develop and incorporate into its 1988 Legislative program to:"

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT THIS RESOLUTION 87-21 BE ADOPTED AS AMENDED (See page 1047)

(Not Final Action of the House)

Your Reference Committe would like to express its appreciation to all members of our Association who appeared at our meeting to provide guidance and counsel, and to Joseph T. Ostroski, M.D., Chairman of the Council on Medical Services.

Special thanks are conveyed to Daniel L. Seckinger Jr., M.D., the AMA Delegate at the meeting of this Reference Committee. I would like to take this opportunity to express my sincere appreciation to members of this Committee: C. Davis Whelchel III, M.D.; David A. D'Allesandro, M.D.; Harold G. Norman, M.D. and Gilbert R. Panzer, M.D.

The Reference Committee would also like to thank FMA staff, Edward D. Hagan and Mrs. Lisa Van Dalen for their assistance in the preparation of this report.

MR. SPEAKER, I MOVE THAT THE REPORT OF THE REFERENCE COMMITTEE II BE ADOPTED (AS AMENDED).

Mr. Speaker, this concludes the report of Reference Committee II.

RESOLUTION 87-19 — SCHOOL-BASED HEALTH CLINICS MINORITY REPORT

David A. D'Allesandro, M.D., Lighthouse Point

Resolution 87-19 should **not** be adopted.

School-Based Health Clinics should be opposed by FMA, because they are not cost-effective. It is not in the interest of the FMA to (apparently) condone adolescent pre-marital sexual activity by endorsing dispensing birth control in public schools.

As medical professionals, leaders in our society and tax payers we are aware that not all children are without proper medical attention, and that School-Based Health Clinics cannot perform comprehensive health care during a short five-day week.

Dr. Joe Zanga, of the Medical College of Virginia and Chairman of the School Health Clinic of the American Academy of Pediatrics, has determined that at an approximate per-visit expense to the tax payer of $35, these clinics are not cost-effective and are of marginal value.

Asta Kenney, of the Guttmacher Institute, reporting the 1985 National School-Based Clinic Conference in Chicago, said that "solid data on the health impact of these clinics is scarce."

In fact, the primary reason for these clinics is not eye, ear and Scoliosis testing, which is a one-time visit and much less expensive; it is, rather, birth control dissemination and sex education.

Sharon Lovick of the Center for Population Options on March 13, 1987 in Washington, D.C., said of School-Based Health Clinics "the impetus for starting these programs in most communities continues to be a goal of doing something about adolescent pregnancies. We can talk all about the fact that we want to open up comprehensive services, but the main focus — the reason people put dollars into it — still turns on the hope, the expectation, that somehow you are going to do something about adolescent pregnancy."

Experience has been that the birth rate drops, as much as 37%, but what has not been shown to drop is the pregnancy rate amongst adolescent females. This explains the strong lobby of planned parenthood and other strong preventive activist groups.

The FMA should not be put in the position to appear to condone irresponsible sex activity in our public schools. It would be far better that we should help guide classroom instruction of sex education and AIDS awareness. That would be worthy of this great society.

(Not Final Action of the House)

III. REFERENCE COMMITTEE ON FINANCE AND ADMINISTRATION

Bruce W. Weissman, M.D., Miami, Chairman
Paul T. Baroco, M.D., Pensacola
Harold L. Ishler Jr., M.D., Clearwater
John B. Adamson, M.D. Cocoa Beach
Miguel R. Alonso, M.D., Tampa
Frank C. Coleman, M.D., Tampa, AMA Delegate Advisor

Mr. Speaker, Mr. President and Members of the House of Delegates:

Your Reference Committee No. III — Finance and Administration — has considered each of the items referred to it and desires to present the following report. The Reference Committee's recommendations on each item will be submitted separately, and I respectfully suggest that each item be acted upon before going to the next.

(1) REMARKS OF THE SPEAKER (Presented at the First Meeting of the House)

Your Reference Committee considered the remarks of the Speaker of the House of Delegates, Dr. Guy T. Selander, and wishes to commend him for the clear and precise rules under which the House of Delegates acts and his summary to us at the beginning of the meeting.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REMARKS OF THE SPEAKER BE ADOPTED AS PRESENTED (See page 937)

(2) PRESIDENT'S ADDRESS (Presented at the First Meeting of the House)

Your Reference Committee considered the President's Address and wishes to commend him for his outstanding leadership on behalf of the members of this Association for the past year.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE PRESIDENT'S ADDRESS BE ADOPTED AS PRESENTED (See page 1005)

(3) REPORT OF PUBLIC RELATIONS OFFICER

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE PUBLIC RELATIONS OFFICER BE ADOPTED AS PRESENTED (See page 1005)

(4) SUPPLEMENTAL REPORT OF PUBLIC RELATIONS OFFICER

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE SUPPLEMENTAL REPORT OF THE PUBLIC RELATIONS OFFICER BE ADOPTED AS PRESENTED (See page 1005)

(5) REPORT OF THE FLORIDA AMA DELEGATION

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE AMA DELEGATION BE ADOPTED AS PRESENTED (See page 1007)

(6) REPORT OF THE COMMITTEE ON MEMBERSHIP DEVELOPMENT

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE COMMITTEE ON MEMBERSHIP DEVELOPMENT BE ADOPTED AS PRESENTED (See page 1011)

(7) REPORT OF THE MEDICAL STUDENT SECTION

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE MEDICAL STUDENT SECTION BE ADOPTED AS PRESENTED (See page 1013)

(Not Final Action of the House)

(8) REPORT OF THE STEERING COMMITTEE FOR THE PROPOSED FMA YOUNG PHYSICIANS SECTION

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE STEERING COMMITTEE FOR THE PROPOSED FMA YOUNG PHYSICIANS SECTION BE ADOPTED AS PRESENTED (See page 1014)

(9) REPORT OF THE JUDICIAL COUNCIL

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE JUDICIAL COUNCIL BE ADOPTED AS PRESENTED (See page 1015)

(10) SUPPLEMENTAL REPORT OF THE JUDICIAL COUNCIL

MR. SPEAKER, YOUR REFERENCE COMMMITTEE RECOMMENDS THAT THE SUPPLEMENTAL REPORT OF THE JUDICIAL COUNCIL BE ADOPTED AS PRESENTED (See page 1015)

(11) REPORT OF THE FLORIDA MEDICAL FOUNDATION

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE FLORIDA MEDICAL FOUNDATION BE ADOPTED AS PRESENTED (See page 1019)

(12) REPORT OF THE PHYSICIANS RECOVERY NETWORK COMMITTEE

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE PHYSICIANS RECOVERY NETWORK COMMITTEE BE ADOPTED AS PRESENTED (See page 1020)

(13) REPORT OF THE FLORIDA PHYSICIANS ASSOCIATION

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE FLORIDA PHYSICIANS ASSOCIATION BE ADOPTED AS PRESENTED (See page 1022)

(14) REPORT OF THE FLORIDA MEDICAL POLITICAL ACTION COMMITTEE

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE FLORIDA MEDICAL POLITICAL ACTION COMMITTEE BE ADOPTED AS PRESENTED (See page 1023)

(15) REPORT OF THE TREASURER

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE TREASURER'S REPORT BE ADOPTED (See page 1024)

(16) REPORTS OF THE BOARD OF GOVERNORS

Mr. Speaker, your Reference Committee considered Report C of the Board of Governors and the accompanying Supplemental Reports of the Board F, G, H, and J and wishes to submit the following recommendations.

REPORT C OF THE BOARD OF GOVERNORS

RECOMMENDATION NO. C-1

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION NO. C-1 BE ADOPTED (See page 956)

RECOMMENDATION NO. C-2

(Not Final Action of the House)

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION NO. C-2 BE ADOPTED (See page 956).

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REMAINDER OF REPORT C BE ADOPTED AS PRESENTED (See page 956)

REPORT F OF THE BOARD OF GOVERNORS

Mr. Speaker, your Reference Committee reviewed carefully and received extensive testimony regarding the FMA's current professional liability activities. Your Committee wishes to acknowledge the excellent presentations before the Committee by Frederick B. Karl; Dr. James Todd, Senior Deputy Executive Vice President of the AMA; John Thrasher and others. Your Reference Committee further wishes to reemphasize the need for a total unified effort in successfully achieving the FMA's professional liability objectives of enacting the Medical Incident Compensation Act (MICA) and the constitutional amendment campaign to place a cap of $100,000 on the amount that can be awarded for noneconomic damages in any liability suit.

Your Reference Committee further wishes to express the critical need for adequate financial support of this effort as reflected in the FMA's Treasurer's Report and recommends that the House of Delegates strongly urge the individual members of their respective medical societies to submit, at the earliest possible time, the $500 voluntary contribution requested by the FMA to help finance the PLI effort.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT REPORT F OF THE BOARD OF GOVERNORS BE ADOPTED AS PRESENTED (See page 974)

REPORT G OF THE BOARD OF GOVERNORS

Mr. Speaker, your Reference Committee considered Report G of the Board of Governors and submits the following recommendations.

RECOMMENDATION NO. G-1

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION NO. G-1 BE ADOPTED (See page 977).

RECOMMENDATION NO. G-2

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION NO. G-2 BE ADOPTED (See page 977).

RECOMMENDATION NO. G-3

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION NO. G-3 BE ADOPTED (See page 977).

RECOMMENDATION NO. G-4

Your Reference Committee noted an error on Line 81. The word "Reciprocal" should be deleted (See page 977).

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION NO. G-4 BE ADOPTED AS CORRECTED (See page 977).

RECOMMENDATION NO. G-5

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RECOMMENDATION G-5 BE ADOPTED (See page 977).

(Not Final Action of the House)

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT REPORT G BE ADOPTED AS AMENDED (See page 977)

REPORT H OF THE BOARD OF GOVERNORS

Mr. Speaker, your Reference Committee reviewed Report H of the Board of Governors regarding the FMA priorities for 1986-87. Your Reference Committee noted the FMA's extensive activities regarding the multiple issues confronting medicine.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT REPORT H OF THE BOARD OF GOVERNORS BE ADOPTED AS PRESENTED (See page 980)

REPORT J OF THE BOARD OF GOVERNORS

Mr. Speaker, your Reference Committee reviewed Report J of the Board of Governors regarding 1986 House of Delegates referrals and resolutions. In keeping with Resolution 86A-14, the disposition of all resolutions enacted by the House of Delegates has been reported to the House as reflected in the Board's report. Your Reference Committee wishes to submit the following recommendations regarding those items referred to the Board of Governors by the House of Delegates in 1986 for further review and recommendations.

RECOMMENDATION NO. J-1

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 86A-3 **NOT** BE ADOPTED (See page 986)

RECOMMENDATION NO. J-2

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 86A-6 **NOT** BE ADOPTED (See page 986)

RECOMMENDATION NO. J-3

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 86A-33 **NOT** BE ADOPTED (See page 000).

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT REPORT J OF THE BOARD OF GOVERNORS BE ADOPTED AS PRESENTED EXCEPT THOSE SECTIONS REFERRED TO OTHER REFERENCE COMMITTEES (See page 986)

RESOLUTIONS:

RESOLUTION 87-2 — CONSTITUTIONAL AMENDMENTS,
Lee County Medical Society

Mr. Speaker, your Reference Committee recommends that Resolution 87-2 be amended by deleting "$250,000" and substituting "$100,000" on Line 9.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-2 BE ADOPTED AS AMENDED (See page 1043)

RESOLUTION 87-4, PAPERWORK REDUCTION,
Sarasota County Medical Society

Mr. Speaker, your Reference Committee recommends that Resolution 87-4 be amended by deleting the words "poll the membership to" and adding after the word determine "through appropriate mechanisms."

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS RESOLUTION 87-4 BE ADOPTED AS AMENDED (See page 1043)

(Not Final Action of the House)

RESOLUTION 87-6, FMA GRIEVANCE PROCEDURES,
Lee County Medical Society

Mr. Speaker, your Reference Committee recommends that Resolution 87-6 be referred to the Board of Governors for review of the adequacy of the Judicial Council's confidentiality safeguards in respect to FMA's grievance procedures and report back to the House of Delegates.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-6 BE REFERRED TO THE BOARD OF GOVERNORS (See page 1044)

RESOLUTION 87-7, MECHANISM FOR POLLING FMA MEMBERS,
Hillsborough County Medical Association

Mr. Speaker, your Reference Committee recommends that Resolution 87-7 be referred to the Board of Governors for development of a mechanism for polling members of the FMA when necessary for determining grass roots sentiment on key issues affecting medicine.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-7 BE REFERRED TO THE BOARD OF GOVERNORS (See page 1044).

RESOLUTION 87-8, FMA LONG-RANGE PLANNING COMMITTEE,
Hillsborough County Medical Association

Mr. Speaker, your Reference Committee recomends the following substitute for Resolution 87-8:

"RESOLVED, That the Board of Governors appoint an Ad Hoc Committee to the Executive Committee (long-range planning committee) with appropriate grassroots representation to provide advice to the Executive Committee for long-range planning."

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS SUBSTITUTE RESOLUTION 87-8 BE ADOPTED (See page 1044)

RESOLUTION 87-9, FMA PROFESSIONAL LIABILITY COMMITTEE,
Hillsborough County Medical Association

Mr. Speaker, your Reference Committee recommends the following substitute for Resolution 87-9:

"RESOLVED, That the Board of Governors maintain a Committee on Professional Liability for an indefinite time and that the Committee have adequate representation from high and low risk specialties."

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS SUBSTITUTE RESOLUTION 87-9 BE ADOPTED (See page 1044)

RESOLUTION 87-13, REINSTATEMENT OF FMA MEMBERSHIP,
Orange County Medical Society

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-13 BE ADOPTED AND REFERRED TO THE COMMITTEE ON BYLAWS FOR REVIEW AND IMPLEMENTATION.

RESOLUTION 87-14, FMA MEMBERSHIP DEVELOPMENT FINANCING FOR COUNTY MEDICAL SOCIETIES,
Orange County Medical Society

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-14 BE ADOPTED (See page 1045)

RESOLUTION 87-15, CONSENT FOR EMERGENCY RESOLUTIONS,
Orange County Medical Society

(Not Final Action of the House)

Mr. Speaker, your Reference Committee recommends that Resolution 87-15 be referred to the Board of Governors for review and recommendation in respect to the overall procedures for submitting emergency resolutions.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-15 BE REFERRED TO THE BOARD OF GOVERNORS (See page 1045)

RESOLUTION 87-16, FLAG CEREMONY,
Orange County Medical Society

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-16 **NOT** BE ADOPTED (See page 1045)

RESOLUTION 87-22, REVIEW OF MEDICAL RECORDS BY GOVERNMENTAL AND INSURANCE AGENCIES,
Dade County Medical Association

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-22 BE ADOPTED (See page 1047)

RESOLUTION 87-23, EMOTIONAL SUPPORT FOR MEDICAL MALPRACTICE DEFENDANTS,
Dade County Medical Association

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-23 BE ADOPTED (See page 1048)

RESOLUTION 87-27, RELOCATION OF FMA ANNUAL MEETINGS,
Dade County Medical Association

Mr. Speaker, your Reference Committee felt that this recommendation was unnecessary in light of the current FMA policy for continuing to evaluate alternate meeting locations for the FMA Annual Meeting throughout the state when deemed financially feasible.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-27 **NOT** BE ADOPTED (See page 1048)

RESOLUTION 87-28, CANDIDATES FOR STATE ELECTIONS,
Manatee County Medical Society

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION NO. 87-28 **NOT** BE ADOPTED (See page 1049)

RESOLUTION 87-32, PROFESSIONAL FOUNDATION FOR HEALTH CARE,
Capital Medical Society

Mr. Speaker, your Reference Committee carefully considered Resolution 87-32 in respect to the lawsuit filed by Dr. Dozier and is sympathetic to the circumstances giving rise to this lawsuit. The Reference Committee felt that there was insufficient information to recommend adoption of the resolution and feels there is a need to further evaluate the legal and financial aspects of the lawsuit.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-32 BE REFERRED TO THE BOARD OF GOVERNORS FOR EVALUATION OF THE LEGAL AND FINANCIAL ASPECTS OF THE LAWSUIT REFERRED TO IN THE RESOLUTION AND DETERMINATION OF THE FEASIBILITY AND APPROPRIATE LEVEL OF SUPPORT (See page 1049)

RESOLUTION 87-33, FLAMEDCO, INC. POLICIES,
Collier County Medical Society

(Not Final Action of the House)

Mr. Speaker, your Reference Committee wishes to make the following changes in Resolution 87-33. On line 11, delete the word "initiate" and add "continue" and on Line 14, after the word "should" add "continue to."

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-33 BE ADOPTED AS AMENDED (See page 1050).

RESOLUTION 87-37, LIABILITY INSURANCE PREMIUMS,
Broward County Medical Association

Mr. Speaker, your Reference Committee recommends that Resolution 87-37 be referred to the Board of Governors to evaluate the intent of the resolution in light of the FMA's overall tort reform objectives and to further study means to make the multi-tiered classification system for establishing professional liability more equitable.

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-37 BE REFERRED TO THE BOARD OF GOVERNORS (See page 1050)

RESOLUTION 87-38, MANDATORY INSURANCE FOR LICENSURE,
Broward County Medical Association

Mr. Speaker, your Reference Committee wishes to note the following typographical error on line 11. The word "legislature" should be "legislation."

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-38 BE ADOPTED (See page 1051)

Mr. Speaker, your Reference Committee wishes to acknowledge the great complexity and magnitude of issues, particularly the professional liability crisis being addressed by the Board of Governors, and commends the Board for its exemplary performance during the past year.

Mr. Speaker, your Chairman wishes to thank each member of this Reference Committee: Paul T. Baroco, M.D.; Harold L. Ishler Jr., M.D.; John B. Adamson, M.D.; Miguel R. Alonso, M.D., and I would also like to thank the AMA Delegate Advisor Frank C. Coleman, M.D.; Mr. Donald C. Jones, Executive Vice President; Mr. John E. Thrasher, Deputy Executive Director and General Council; Ms. Lynn Mobarak and Ms. Linda Flowers, Recorders and FMA staff members for their support of the Committee and the many members of the Association who attended our meeting and presented testimony.

MR. SPEAKER, I MOVE ADOPTION OF THE REPORT OF REFERENCE COMMITTEE III (AS AMENDED).

Mr. Speaker, this completes the report of Reference Committee III.

IV. REFERENCE COMMITTEE ON LEGISLATION AND MISCELLANEOUS

Juan S. A. Wester, M.D., Ft. Lauderdale, Chairman
Gaston J. Acosta-Rua, M.D., Jacksonville
David L. Thomas, M.D., Venice
James A. Gordon, M.D., Ft. Lauderdale
Julian H. Groff, M.D., Miami Beach
T. Byron Thames, M.D., Orlando, AMA Delegate Advisor

Mr. Speaker and Members of the House of Delegates:

(Not Final Action of the House)

Your Reference Committee No. IV — Legislation and Miscellaneous — has considered the items referred to it and heard testimony from members of the Florida Medical Association about them.

The Committee would like to commend publicly Dr. Louis C. Murray for his continued outstanding work in his role as Chairman of the Council on Legislation. Furthermore, your Committee would like to give proper recognition and commendation to T. Wallace Hahn, M.D., Chairman of the Committee on State Legislation, Mr. Donald S. Fraser Jr., Deputy Executive Director, Legislation and Public Affairs, and Mr. George S. Palmer Jr., Assistant Director, Legislative Affairs. After working for many years with Mr. Fraser and Mr. Palmer, I would like to make a special comment that without them I have no doubt this organization and all our lives would not be the same. A special thanks to Ms. Lucy Mohs, Assistant Director, Legislative Affairs, and all other FMA staff members who have provided outstanding support of our legislative programs. Your Committee would also like to recognize the contributions of all members of the Florida Medical Association who have participated in FMA legislative activities during the past year.

Your Reference Committee's recommendations on each item will be submitted separately and I respectfully request that each item be acted upon before proceeding to the next.

(1) REPORT OF THE COUNCIL ON LEGISLATION

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE COUNCIL ON LEGISLATION BE ADOPTED (See page 1025)

(2) SUPPLEMENTAL REPORT OF THE COUNCIL ON LEGISLATION

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT THE SUPPLEMENTAL REPORT OF THE COUNCIL ON LEGISLATION BE ADOPTED (See page 1025)

(3) BOARD OF GOVERNORS REPORT D

Your Reference Committee would like to commend publicly members of the Florida Medical Association Board of Governors for their tireless assistance in achieving the Association's legislative objectives. In particular, James B. Perry, M.D., Florida Medical Association President, is to be commended for his outstanding leadership and unselfish contributions to the well-being of our Association.

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT THE BOARD OF GOVERNORS REPORT D BE ADOPTED (See page 968)

(4) BOARD OF GOVERNORS REPORT J

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT THE BOARD OF GOVERNORS REPORT J BE ADOPTED AS PRESENTED EXCEPT THOSE SECTIONS REFERRED TO OTHER REFERENCE COMMITTEES (See page 986)

RESOLUTIONS:

The Committee considered 10 resolutions referred to it by the Speaker of the House. Much testimony, both pro and con, were heard on most of these and many side issues were brought to the attention of the Committee. After much study and consideration, the following recommendations are presented to the House.

RESOLUTION 87-11 — CIGARETTE SALE TO MINORS,
Hillsborough County Medical Association

Mr. Speaker, your Reference Committee recommends that the following change be made to this resolution:

(Not Final Action of the House)

Strike all of line 15 and insert new language: "Legislature to amend Chapter 859.06, Florida Statutes, to strengthen appropriate penalties for sale and"

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-11, CIGARETTE SALE TO MINORS STATUTE, BE ADOPTED AS AMENDED (See page 1044)

RESOLUTION 87-12 — REPEAL OF FIVE-HOUR RISK MANAGEMENT RULE, Hillsborough County Medical Association

The Committee, noting that this resolution has considerable merit, felt the timing was inappropriate but would like it considered at a future date.

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-12, REPEAL OF FIVE-HOUR RISK MANAGEMENT RULE, **NOT** BE ADOPTED (See page 1045)

RESOLUTION 87-24 — SUBSTITUTION OF GENERIC DRUGS, Dade County Medical Association

Mr. Speaker, your Reference Committee recommends that the following changes be made to this resolution:

Strike all of lines 13 through 15.

Strike all of lines 17-20 and insert: "require that the pharmacist fill the prescription as written unless the physician checks off a box indicating that substitution is allowed."

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-24, SUBSTITUTION OF GENERIC DRUGS, BE ADOPTED AS AMENDED (See page 1048)

RESOLUTION 87-25 — DISPENSING BY PHYSICIANS, Dade County Medical Association

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-25, DISPENSING BY PHYSICIANS, BE ADOPTED (See page 000).

RESOLUTION 87-30 — PHYSICIAN ADVOCACY FOR INDIGENT HEALTH CARE, Hillsborough County Medical Association

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-30, PHYSICIAN ADVOCACY FOR INDIGENT HEALTH CARE, BE REFERRED TO THE BOARD OF GOVERNORS (See page 1049).

RESOLUTION 87-31 — SALES TAX ON MEDICAL COLLECTION, Collier County Medical Society

MR. SPEAKER, DUE TO THE UNCERTAINTY OF THE CURRENT SALES TAX ON SERVICES SITUATION IN THE STATE, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-31, SALES TAX ON MEDICAL COLLECTION, **NOT** BE ADOPTED (See page 1049).

RESOLUTION 87-34 — TAX DEDUCTIBILITY OF MEDICAL STUDENT LOAN INTEREST, Medical Student Section Governing Council

Mr. Speaker, your Reference Committee recommends the following change be made to this resolution:

On line 14, strike the word "medical".

(Not Final Action of the House)

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-34, TAX DEDUCTIBILITY OF MEDICAL STUDENT LOAN INTEREST, BE ADOPTED AS AMENDED (See page 1050)

RESOLUTION 87-35 — INFECTIOUS MEDICAL WASTE,
Dade County Medical Association

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-35, INFECTIOUS MEDICAL WASTE, BE ADOPTED (See page 1050)

RESOLUTION 87-36 — EXPERT WITNESS,
Brevard County Medical Society

Mr. Speaker, your Reference Committee recommends the following changes to this resolution:

On line 16, insert a period after the word "years", strike the remaining language on line 16 and strike line 17.

On line 21, strike the period, insert a semicolon and insert "and be it further RESOLVED, that the Florida Medical Association be encouraged to make available a list of expert witnesses for each specialty."

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-36, EXPERT WITNESS, BE ADOPTED AS AMENDED (See page 1050)

RESOLUTION 87-40 — LIMITED LICENSED PRACTITIONERS,
Broward County Medical Association

Mr. Speaker, the Reference Committee recommends that the following changes be made to this resolution:

On line 6, delete "limited licensed practitioners" and insert "allied health care practitioners not licensed under Chapters 458, 459 and 466, Florida Statutes".

MR. SPEAKER, THE REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-40, LIMITED LICENSED PRACTITIONERS, BE REFERRED TO THE BOARD OF GOVERNORS AS AMENDED FOR REAFFIRMATION OF EXISTING POLICY (See page 1051)

Your Chairman wishes to thank all members of the Florida Medical Association who appeared before this Committee. I would also like to thank the members of this Committee, Gaston J. Acosta-Rua, M.D., David L. Thomas, M.D., James A. Jordan, M.D., Julian H. Groff, M.D., and T. Byron Thames, M.D., AMA Delegate Advisor.

Mr. Speaker, this concludes the report of Reference Committee IV.

MR. SPEAKER, I MOVE THAT THE REPORT OF REFERENCE COMMITTEE IV BE ADOPTED (AS AMENDED).

V. REFERENCE COMMITTEE ON MEDICAL ECONOMICS

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(Not Final Action of the House)

Mr. Speaker, Mr. President and Members of the House of Delegates:

Reference Committee No. V — Medical Economics — has considered each of the items referred to it and desires to present the following report. Your Reference Committee's recommendations on each item will be submitted separately, and I respectively suggest each item be acted upon before going on to the next.

(1) REPORT OF THE COUNCIL ON MEDICAL ECONOMICS

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE COUNCIL ON MEDICAL ECONOMICS BE ADOPTED AS PRESENTED (See page 1032)

(2) SUPPLEMENTAL REPORT OF THE COUNCIL ON MEDICAL ECONOMICS

Mr. Speaker, your Reference Committee recommends that the Supplemental Report of the Council on Medical Economics be amended by adding the words "reaffirm its opposition to Medicare mandatory assignment and" on line 70 after the word "Governors" and by deleting line 74 after the word "assignment" and by deleting lines 75 through 83, to read as follows:

"THAT THE FMA BOARD OF GOVERNORS REAFFIRM ITS OPPOSITION TO MEDICARE MANDATORY ASSIGNMENT AND DEVELOP A COURTESY CARD PROGRAM SIMILAR TO THE ONE ENACTED BY THE CONNECTICUT STATE MEDICAL SOCIETY AS AN ALTERNATIVE TO MANDATED MEDICARE ASSIGNMENT."

Your Reference Committee also recommends that the Supplemental Report of the Council on Medical Economics also be amended by adding the words "most current" on line 96 after the word "the" and by deleting the word "IV" on line 96 after the word "CPT".

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE SUPPLEMENTAL REPORT — COUNCIL ON MEDICAL ECONOMICS BE ADOPTED AS AMENDED (See page 1032)

(3) REPORT OF THE COUNCIL ON HOSPITAL MEDICAL STAFFS

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT THE REPORT OF THE COUNCIL ON HOSPITAL MEDICAL STAFFS BE ADOPTED AS PRESENTED (See page 1040)

(4) REPORT E OF THE BOARD OF GOVERNORS

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT REPORT E OF THE BOARD OF GOVERNORS BE ADOPTED AS PRESENTED (See page 971)

(5) REPORT J OF THE BOARD OF GOVERNORS

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT REPORT J OF THE BOARD OF GOVERNORS ON THE RESOLUTIONS LISTED BELOW BE ADOPTED: RESOLUTION 86A-28, RESOLUTION 86A-29, RESOLUTION 86A-31, RESOLUTION 86A-35, RESOLUTION 86A-39, AND EMERGENCY RESOLUTION — WORKERS' COMPENSATION REIMBURSEMENT SCHEDULE (See page 986)

RESOLUTIONS:

RESOLUTION 87-1 — PRO PROVISIONS,
Lee County Medical Society

RESOLUTION 87-3 — PRO PROVISIONS,
Panhandle Medical Society

(Not Final Action of the House)

RESOLUTION 87-5 — PRO PROVISIONS,
Capital, Dade, Hillsborough, Lake, Manatee, Pinellas and Sarasota County Medical Societies

Detailed testimony was heard before your Reference Committee in support of these resolutions regarding the PRO. Your Reference Committee recommends that Substitute Resolution 87-1 — PRO Provisions be adopted in lieu of Resolution 87-1, 87-3 and 87-5, to read as follows:

"RESOLVED, That the Florida Medical Association and the American Medical Association seek legislation to significantly revise the professional review organization statutes as now written and implemented through HCFA guidelines to reflect the community standards for quality of care."

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT SUBSTITUTE RESOLUTION 87-1 BE ADOPTED (See page 1043)

RESOLUTION 87-26 — PAYMENT FOR PHYSICIANS' SERVICES,
Dade County Medical Association

Your Reference Committee heard testimony in support of this resolution and recommends that Resolution 87-26 — Payment for Physicians' Services be amended by adding the words "to the public" on line 28 after the word "reaffirm.".

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-26 — PAYMENT FOR PHYSICIAN'S SERVICES BE ADOPTED AS AMENDED (See page 1048)

RESOLUTION 87-39 — LAWSUIT AGAINST PRO,
Polk County Medical Association

Your Reference Committee heard testimony in support of this resolution and recommends that Resolution 87-39 — Lawsuit Against PRO be amended by deleting line 18 after the word "lawsuit"; deleting line 19; and by adding the words "filed by over fifty Florida hospitals against the Health Care Financing Administration" on line 18 after the word "lawsuit".

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-39 — LAWSUIT AGAINST PRO BE APPROVED AS AMENDED (See page 1051)

RESOLUTION 87-41 — MEDICARE REIMBURSEMENT SCHEDULES,
Broward County Medical Association

Your Reference Committee heard testimony in support of this resolution and recommends that Resolution 87-41 — Medicare Reimbursement Schedules be amended by deleting the word "Medicare" and adding the word "Maximum" on line 8 ater the word "That"; by deleting the words "fee splitting procedure" and replacing with the words "dual fee schedule" on line 9 after the word "a"; and by deleting the words "conflicts with" on line 9 after the word "which" and deleting the words "the ethics of the profession" on line 10; adding the words "unfairly discriminates against a large number of physicians" on line 9 after the word "which" to read as follows:

"RESOLVED, That Maximum Actual Allowable Charges (MAACs) appear to be a dual fee schedule which unfairly discriminates against a large number of physicians; and be it further"

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-41 BE ADOPTED AS AMENDED (See page 1051).

(Not Final Action of the House)

RESOLUTION 87-42 — MEDICARE,
Sarasota County Medical Society

Testimony was heard from various members in support of this resolution. Your Reference Committee recommends that Resolution 87-42 be amended by deleting the words "James B. Perry, M.D." on line 14 after the word "President"; deleting the word "such" on line 16 after the word "with"; deleting words "insults the members of the FMA" on line 17 after the word "which"; and adding the words "is abusive to physicians and indicts them as the single cause for Medicare cost overruns" on line 17 after the word "which".

MR. SPEAKER, YOUR REFERENCE COMMITTEE RECOMMENDS THAT RESOLUTION 87-42 — MEDICARE BE ADOPTED AS AMENDED (See page 1051)

Mr. Speaker, your Reference Committee expresses gratitude to all FMA members and staff who appeared before the Committee.

Your Reference Committee Chairman was fortunate to work with a most efficient and informed Committee, John E. Perchalski, M.D., Cecil B. Wilson, M.D., Sheldon Zane, M.D., Darrel W. Wyatt, M.D., and Charles J. Kahn, M.D., AMA Delegate Advisor, and also wishes to express his appreciation to Charles P. Hayes Jr., M.D., Chairman of the Council on Medical Economics, and T.M. "Dan" Daniel, M.D., Chairman of the Council on Hospital Medical Staffs for their outstanding effort on behalf of FMA members this past year.

The Reference Committee would also like to thank Mrs. Betty Daly, Robert W. Seligson, M.B.A., and Gregory E. Hill for their able assistance in the preparation of this report.

MR. SPEAKER, I MOVE THAT THE REPORT OF REFERENCE COMMITTEE NO. V BE ADOPTED (AS AMENDED).

Mr. Speaker, this concludes the report of the Reference Committee No. V.

(Not Final Action of the House)

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WALTON — Absent

WASHINGTON — Absent

SPEAKER OF HOUSE — Guy T. Selander, M.D.

VICE SPEAKER — Arthur L. Eberly Jr., M.D.

MEMBER APPOINTED FROM THE HOSPITAL MEDICAL STAFFS COUNCIL — Absent

MEMBER APPOINTED FROM MEDICAL STUDENT SECTION — Absent

SPECIALTY GROUP DELEGATE 1987 FIRST HOUSE

Allergy and Immunology Soc., Fla. — Michael Diamond, M.D.

Anesthesiologists, Florida Soc. of — Jimmy D. Moore, M.D.

Chest Physicians, Amer. Coll. of Fla. Chapter — W. Michael Alberts, M.D.

Emergency Physicians, Amer. Coll. of Fla. Chap. — Emmet B. Ferguson, M.D.

Family Physicians, Fla. Academy of — John E. Perchalski, M.D.

Gastroenterologic Soc., Fla. — Ross T. Krueger, M.D.

Nephrology, Fla. Soc. of — David S. Pins, M.D.

Obstetric & Gynecologic Soc., Fla. — Robert Hoover, M.D.

Pathologists, Fla. Soc. of — Wayne H. Schrader, M.D.

Pediatric Surgeons, Fla. Assn. of — Malvin Weinberger, M.D.

Plastic and Reconstructive Surgeons, Fla. Soc. of — Mutaz B. Habal, M.D.

Preventive Medicine, Fla. Soc. for — E. Charlton Prather, M.D.

Psychiatric Assn., Council of Fla. Dist. Branches of the American — George W. Metcalf, M.D.

Thoracic Society, Fla. — John R. Ibach, M.D.

Urological Society, Fla. — William R. Jones, M.D.

SPECIALTY GROUPS WITH NO DELEGATE REPRESENTATION AT THE FIRST HOUSE

Colon and Rectal Surgeons, Fla. Soc. of

Dermatology, Fla. Soc. of

Dermatologic Surgeons, Fla. Soc. of

Endocrine Society, Fla.

Internal Medicine, Fla. Soc. of

Neonatal Perinatologists, Fla. Soc. of

Neurology, Fla. Soc. of

Neurosurgical Society, Fla.

Nuclear Physicians, Fla. Assn. of

Occupational Medical Assn., Fla.

Oncology, Fla. Soc. of Clinical

Ophthalmology, Fla. Soc. of

Orthopedic Society, Fla.

Otolaryngology, Head & Neck Sur., Fla. Soc. of

Pediatric Cardiologists, Fla. Assn. of

Pediatric Soc., Fla. and Pediatrics, American Academy, Fla. Chapter

Physical Medicine and Rehab., Fla. Soc. of

Physicians, American College of, Fla. Region

Radiological Society, Fla.

Rheumatology, Fla. Soc. of

Surgeons, Amer. College of, Fla. Chapter

Surgeons, Fla. Assn. of General

Surgeons, International College of, Fla. State Surgical Division

Thoracic and Cardiovascular Surgeons, Fla. Soc. of

1987 DELEGATES
SECOND HOUSE OF DELEGATES

ALACHUA — O. Frank Agee, M.D.; Robert K. Casey, M.D.; Thomas D. Bartley, M.D.; James O. Dailey, M.D.; Thomas H. Moore Jr., M.D.; Gerold L. Schiebler, M.D.

BAY — James T. Cook III, M.D.; Ted R. Wilson, M.D.

BRADFORD — Carlos M. Hernandez, M.D.

BREVARD — John B. Adamson, M.D.; Hani M. Agrama, M.D.; Richard I. Barr, M.D.; Glenn E. Bryan, M.D.; Antonio U. Catasus, M.D.; Onofre P. Carrillo, M.D.; Daniel Roberts, M.D.; Robert C. Ufferman, M.D.; Joseph C. Von Thron, M.D.

BROWARD — Bruce B. Burgess, M.D.; Phillip A. Caruso, M.D.; David A. D'Allesandro, M.D.; Andre S. Capri, M.D.; George T. Edwards, M.D.; Ronald B. Fauer, M.D.; Ira Finegold, M.D.; Paul A. Flaten, M.D.; Gerard D. Grau, M.D.; James A. Jordan, M.D.; Linda Kaplan, M.D.; George I. May, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Roland K. Molinet, M.D.; Jerry D. Moore, M.D.; Richard F. Ott, M.D.; Arthur E. Palamara, M.D.; Donald J. Plevy, M.D.; Richard D. Shafron, M.D.; Don E. Sokolik, M.D.; Marvin L. Stein, M.D.; Barry S. Tepperman, M.D.; Peter A. Tomasello, M.D.; Dana V. Wallace, M.D.; Juan Sven Aage Wester, M.D.

CAPITAL — Laurie L. Dozier Jr., M.D.; Charles J. Holland, M.D.; Robert P. Johnson, M.D.; George N. Lewis, M.D.; Terence P. McCoy, M.D.; David D. Miles, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS — R. Edward Dodge Jr., M.D.

CLAY — Darrel W. Wyatt, M.D.

COLLIER — Charles S. Eytel, M.D.; Charles J. Montgomery, M.D.; Virgil A. Ponzoli Jr., M.D.; Jack J. Schneider, M.D.

COLUMBIA — Najunda Swamy, M.D.

DADE — Edward R. Annis, M.D.; Allen Baumal, M.D.; Jerome Benson, M.D.; Robert E. Boyett, M.D.; James W. Bridges, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Ronald J. Cantwell, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Barbara S. Drabkin, M.D.; Charles A. Dunn, M.D.; Jerry E. Enis, M.D.; Byron D. Epstein, M.D.; Edward J. Feller, M.D.; Miguel Figueroa, M.D.; Denio O. Fonseca, M.D.; Humberto L. Fontana, M.D.; Simon J.H. Frank, M.D.; N. Ralph Frankel, M.D.; Richard L. Glatzer, M.D.; Paul A. Gluck, M.D.; Alan S. Graubert, M.D.; Julian H. Groff, M.D.; Joan L. Harris, M.D.; Joseph Harris, M.D.; James J. Hutson, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda A. Marraccini, M.D.; William T. Mixson, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto, M.D.; Pedro A. Ramos, M.D.; Jeffrey B. Raskin, M.D.; William I. Roth, M.D.; Glenn L. Salkind, M.D.; A. Frederick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C.S. Skinner, M.D.; Douglas Slavin, M.D.; Emilio A. Trujillo, M.D.; Osvaldo D. Valdes, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Daniel N. Weingrad, M.D.; Steven M. Weissberg, M.D.; Bruce W. Weissman, M.D.; Sheldon Zane, M.D.

DESOTO-HARDEE-GLADES — Kayum Mohammadbhoy, M.D.

DUVAL — Gaston J. Acosta-Rua, M.D.; Scott B. Baker, M.D.; James W. Clower, M.D.; Clyde M. Collins, M.D.; James H. Corwin II, M.D.; Patricia C. Cowdery, M.D.; Wilbert L. Dawkins Sr., M.D.; Daniel E. Fulmer, M.D.; James E. Glenn, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Apolinar C. Ilano, M.D.; Benjamin A. Johnson, M.D.; Marc D. Kaye, M.D.; John F. Lovejoy Jr., M.D.; Richard S. Lucie, M.D.; W. Gray Mason, M.D.; Charles B. McIntosh, M.D.; Charles T. Montgomery, M.D.; Kurt W. Mori, M.D.; Walter E. Morris Jr., M.D.; Belton C. Ray Jr., M.D.; Walter Smithwick III, M.D.; Nimrod H. Tucker, M.D.; Laura Ureta, M.D.; Carl D. Whelchel III, M.D.

ESCAMBIA — Paul T. Baroco, M.D.; James W. Carruth Jr., M.D.; Richard H. Ciordia, M.D.; Eric F. Geiger, M.D.; Everett S. Havard, M.D.; Charles J. Kahn, M.D.; James M. Potter, M.D.; Michael R. Redmond, M.D.

FLAGLER — (Absent)

FRANKLIN-GULF — (Absent)

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — Joseph A. Mitchell, M.D.; Luis M. Pena, M.D.

HILLSBOROUGH — Miguel R. Alonso, M.D.; Pierre J. Bouis, M.D.; William T. Branch, M.D.; Frank C. Coleman, M.D.; Irving M. Essrig, M.D.; W. Hunter Eubanks, M.D.; John C. Fletcher, M.D.; Frank L. France, M.D.; Joel D. Fyvolent, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Waite S. Kirkconnell, M.D.; Donald S. Kwalick, M.D.; Hernan Leon, M.D.; Thomas E. McKell, M.D.; J. Robert Qualey, M.D.; Frederick A. Reddy, M.D.; David T. Rowlands, M.D.; Ralph E. Rydell, M.D.; Daniel J. Sprehe, M.D.; Richard G. Spurlock, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.

INDIAN RIVER — Randall D. Bertolette, M.D.; Kip G. Kelso, M.D.; John W. McDonald, M.D.; Michael B. Zimmer, M.D.

LAKE — Dan. A. Boggus, M.D.; John L. Geeslin, M.D.; Joseph E. Holland, M.D.; William H. Shutze, M.D.

LEE — William R. Bess Jr., M.D.; Robert J. Brueck, M.D.; Larry P. Garrett, M.D.; Marcus McDuffie Moore, M.D.; Rodger W. Shaver, M.D.; Theron T. Knight, M.D.

MADISON — Absent

MANATEE — Thomas R. Busard, M.D.; Julian Giraldo, M.D.; Marc S. Kallins, M.D.; Clyde L. Skene Jr., M.D.

MARION — Henry L. Harrell Jr., M.D.; William A. Trice, M.D.; Richard B. Van Eldik, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D.

MONROE — Absent

NASSAU — Charles M. Tomlinson, M.D.

OKALOOSA — David R. Arrowsmith, M.D.; William W. Thompson, M.D.

ORANGE — Richard J. Bagby, M.D.; Pedro P. Diaz, M.D.; Wayne L. Godbold, M.D.; Alfred Heydrich, M.D.; Jay M. Hughes, M.D.; Angelo Massaro, M.D.; Joseph G. Matthews, M.D.; Franklin B. McKechnie, M.D.; Keith McManus, M.D.; Louis C. Murray, M.D.; Calvin Ronald Peters, M.D.; Wallace M. Philips Jr., M.D.; James F. Richards Jr., M.D.; Robert N. Serros, M.D.; Philip N. Styne, M.D.; Philip G. St. Louis, M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D.

OSCEOLA — Alonzo J. Logan, M.D.

PALM BEACH — Roberto E. Acosta, M.D.; Joe A. Baker, M.D.; Elizabeth J. Barice, M.D.; McKinley Cheshire, M.D.; Ralph R. Eastridge, M.D.; D.P. Falticeni, M.D.; Lee A. Fischer, M.D.; John A. Hildreth, M.D.; John P. Katona, M.D.; Irving B. Lees, M.D.; Catherine Lowe, M.D.; V. A. Marks, M.D.; Mas G. Massoumi, M.D.; Gilbert R. Panzer, M.D.; Joseph F. Phillips, M.D.; Richard Raborn, M.D.; James F. Smith, M.D.; Joe F. Smith, M.D.; Anthony L. Thebaut, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; Penington R. Wimbush, M.D.

PANHANDLE — Herbert E. Brooks, M.D.; Michael J. Stokes, M.D.

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony P. Garritano, M.D.; William E. Hale, M.D.; James Hallock, M.D.; Kay K.

Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris J. Levine, M.D.; Louis Michaelos, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; Jack N. Rothman, M.D.; Joseph Turbin, M.D.; Tom H. West, M.D.; Robert H. Zieburtz, M.D.

POLK — Annette C. Barnes, M.D.; Ray F. Barnes, M.D.; Francis D. Drake, M.D.; Richard M. Garcia, M.D.; John W. Glotfelty, M.D.; Donald I. Gale, M.D.; David T. Jones, M.D.; Robert B. Peddy, M.D.; Wilton M. Reaves Jr., M.D.; Dale L. Taylor, M.D.; Daniel W. Welch, M.D.

PUTNAM — Roy E. Campbell, M.D.

ST. LUCIE-OKEECHOBEE — Khalil A. Cassimally, M.D.; Jack W. Barrett, M.D.; Manuel G. Garcia, M.D.

SANTA ROSA — David Bruce Young, M.D.

SARASOTA — William E. Bush, M.D.; John N. Carlson, M.D.; George M. Coggan, M.D.; Kenneth C. Kiehl, M.D.; Charles R. Mathews, M.D.; Franklin H. Pfeiffenberger, M.D.; Robert R. Lastomirsky, M.D.; Karl R. Rolls, M.D.; David L. Thomas, M.D.

SEMINOLE — Victor J. Bilotta, M.D.; Gonzalo Huaman, M.D.; Lawrence D. Kelley, M.D.; James E. Quinn, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — Absent

TAYLOR — Absent

VOLUSIA — James P. Carey, M.D.; H. Frank Farmer Jr., M.D.; Martin S. Feigenbaum, M.D.; Richard Huster, M.D.; Alvin E. Smith, M.D.; Stephen S. Spore, M.D.; Charles A. Stump, M.D.; H.S. Budd Treloar, M.D.

WALTON — Absent

WASHINGTON — Absent

SPEAKER OF HOUSE — Guy T. Selander, M.D.

VICE SPEAKER — Arthur L. Eberly, M.D.

MEMBER APPOINTED FROM THE HOSPITAL MEDICAL STAFFS COUNCIL — Absent

MEMBER APPOINTED FROM MEDICAL STUDENT SECTION — Mr. Robert Blais

SPECIALTY GROUP DELEGATES 1987 SECOND HOUSE

Allergy and Immunology Society, Fla. — Michael Diamond, M.D.

Anesthesiologists, Fla. Soc. of — Jimmy D. Moore, M.D.

Chest Physicians, Amer. Coll. of Fla. Chapter — W. Michael Alberts, M.D.

Dermatology, Fla. Soc. of — Clifford W. Lober, M.D.

Emergency Physicians, Am. Coll. of Fla. Chap. — Emmet F. Ferguson, M.D.

Family Physicians, Fla. Academy of — John E. Perchalski, M.D.

Gastroenterologic Soc., Fla. — Ross T. Krueger, M.D.

Internal Medicine, Fla. Soc. of — Robert T. Meade, M.D.

Obstetric & Gynecologic Soc., Fla. — Robert Hoover, M.D.

Orthopedic Society, Fla. — Arthur Pearl, M.D.

Pathologists, Fla. Soc. of — Wayne H. Schrader, M.D.

Pediatric Surgeons, Fla. Assn. of — Malvin Weinberger, M.D.

Plastic and Reconstructive Surgeons, Fla. Soc. of — Mutaz B. Habal, M.D.

Preventive Medicine, Fla. Soc. for — E. Charlton Prather, M.D.

Psychiatric Assn., Council of Fla. Dist. Branches of the American — George W. Metcalf, M.D.

Radiological Society, Fla. — Robert Pomerantz, M.D.

Urological Society, Fla. — William R. Jones, M.D.

SPECIALTY GROUPS WITH NO DELEGATE REPRESENTATION PRESENT AT SECOND HOUSE

Colon and Rectal Surgeons, Fla. Soc. of
Dermatologic Surgeons, Fla. Soc. of
Endocrine Society, Fla.
Neonatal Perinatologists, Fla. Soc. of
Nephrology, Fla. Soc. of
Neurology, Fla. Soc. of
Neurosurgical Society, Fla.
Nuclear Physicians, Fla. Assn. of
Occupational Medical Assn., Fla.
Ophthalmology, Fla. Soc. of
Oncology, Fla. Soc. of Clinical
Otolaryngology, Head & Neck Sur., Fla. Soc. of
Pediatric Cardiologists, Fla. Assn. of
Pediatric Soc., Fla. and Pediatrics, American Academy, Fla. Chapter
Physical Medicine and Rehab., Fla. Soc. of
Physicians, American College of, Fla. Region
Rheumatology, Fla. Soc. of
Surgeons, Amer. College of, Fla. Chapter
Surgeons, Fla. Assn. of General
Surgeons, International College of, Fla. State Surgical Division
Thoracic and Cardiovascular Surgeons, Fla. Soc. of
Thoracic Society, Fla.

1987 DELEGATES
THIRD HOUSE OF DELEGATES

ALACHUA — O. Frank Agee, M.D.; Robert K. Casey, M.D.; Thomas H. Moore, M.D.; Gerold L. Scheibler, M.D.

BAY — James T. Cook III, M.D.; Ted R. Wilson, M.D.

BRADFORD — Carlos M. Hernandez, M.D.

BREVARD — John B. Adamson, M.D.; Hani M. Agrama, M.D.; Richard I. Barr, M.D.; Glenn E. Bryan, M.D.; Onofre P. Carrillo, M.D.; Antonio U. Catasus, M.D.; Daniel Roberts, M.D.; Robert C. Ufferman, M.D.; Joseph C. Von Thron, M.D.

BROWARD — Bruce B. Burgess, M.D.; Andre Capi, M.D.; David A. D'Alessandro, M.D.; George T. Edwards, M.D.; Ronald B. Fauer, M.D.; Paul A. Flaten, M.D.; Gerard D. Grau, M.D.; James A. Jordan, M.D.; Linda Kaplan, M.D.; George I. May, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Roland K. Molinet, M.D.; Jerry D. Moore, M.D.; Richard Ott, M.D.; Arthur E. Palamara, M.D.; Donald J. Plevi, M.D.; Ernest G. Sayfie, M.D.; Richard D. Shafron, M.D.; Don E. Sokolik, M.D.; Frederick Smith, M.D.; Peter A. Tomasello, M.D.; Dana V. Wallace, M.D.; Juan S. A. Wester, M.D.

CAPITAL — Laurie L. Dozier Jr., M.D.; Charles J. Holland, M.D.; Robert P. Johnson, M.D.; George N. Lewis, M.D.; Terence P. McCoy, M.D.; David D. Miles, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS -- R. Edward Dodge Jr., M.D.

COLLIER — Charles S. Eytel, M.D.; Charles J. Montgomery, M.D.; Virgil Ponzoli Jr., M.D.; Jack J. Schneider, M.D.

COLUMBIA — Nanjunda Swamy, M.D.

CLAY — Hinson L. Stephens, M.D.; Darrel W. Wyatt, M.D.

DADE — Edward R. Annis, M.D.; Allen Baumal, M.D.; Jerome Benson, M.D.; Robert E. Boyett, M.D.; James W. Bridges, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Ronald J. Cantwell, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Barbara Drabkin, M.D.; Charles A. Dunn, M.D.; Jerry E. Enis, M.D.; Byron D. Epstein, M.D.; Edward J. Feller, M.D.; Miguel Figueroa, M.D.; Humberto L. Fontana, M.D.; N. Ralph Frankel, M.D.; Richard L. Glatzer, M.D.; Paul A. Gluck, M.D.; Alan S. Graubert, M.D.; Julian H. Groff, M.D.; Joan L. Harris, M.D.; Joseph Harris, M.D.; James J. Hutson, M.D.; Donald E. Johnson, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda A. Marraccini, M.D.; William T. Mixson, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto, M.D.; Pedro A. Ramos, M.D.; Jeffrey B. Raskin, M.D.; Edward L. Reid, M.D.; William I. Roth, M.D.; Glenn L. Salkind, M.D.; A. Frederick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C. S. Skinner, M.D.; Douglas Slavin, M.D.; Osvaldo D. Valdes, M.D.; Edgar Webb, M.D.; Harold H. Weiner, M.D.; Daniel N. Weingrad, M.D.; Bruce W. Weissman, M.D.; Sheldon Zane, M.D.

DESOTO-HARDEE-GLADES — Kayum Mohammadbhoy, M.D.

DUVAL — Scott Baker, M.D.; James W. Clower, M.D., Clyde M. Collins, M.D.; James H. Corwin II, M.D.; Patricia C. Cowdery, M.D., Wilbert L. Dawkins Sr., M.D., Daniel E. Fulmer, M.D.; James E. Glenn, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Apolinar C. Ilano, M.D.; Benjamin A. Johnson, M.D.; Marc D. Kaye, M.D.; John F. Lovejoy, M.D.; Richard S. Lucie, M.D.; W. Gray Mason, M.D.; Charles B. McIntosh, M.D., Charles T. Montgomery, M.D.; Kurt W. Mori, M.D.; Walter E. Morris Jr., M.D.; Benton C. Ray Jr., M.D.; Walter Smithwick III, M.D.; Nimrod H. Tucker, M.D.; Laura Ureta, M.D.; Carl D. Whelchel III, M.D.

ESCAMBIA — Paul T. Baroco, M.D.; James W. Carruth Jr., M.D.; Richard H. Cirodia, M.D.; Eric F. Geiger,

M.D., Everett S. Havard, M.D.; Charles J. Kahn, M.D.; James M. Potter, M.D.; Michael R. Redmond, M.D.

FLAGLER — Absent

FRANKLIN-GULF — Absent

HERNANDO — Clinton J. McCrew Jr., M.D.

HIGHLANDS — Joseph A. Mitchell, M.D.; Luis M. Pena, M.D.

HILLSBOROUGH — Miguel R. Alonso, M.D.; Pierre J. Bouis Jr., M.D.; William T. Branch, M.D.; Frank C. Coleman, M.D.; W. Hunter Eubanks, M.D.; John C. Fletcher, M.D.; Frank L. France, M.D.; Joel D. Fyvolent, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Waite S. Kirkconnell, M.D.; Donald S. Kwalick, M.D.; Hernan Leon, M.D.; Thomas E. McKell, M.D.; J. Robert Qualey, M.D.; Frederick A. Reddy, M.D.; David Rowlands, M.D.; Ralph E. Rydell, M.D.; Daniel J. Sprehe, M.D.; Richard G. Spurlock, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.

INDIAN RIVER — Randall D. Bertolette, M.D.; Kip G. Kelso, M.D.; John W. McDonald, M.D.; Michael B. Zimmer, M.D.

LAKE — Dan A. Boggus, M.D.; John L. Geeslin, M.D.; Joseph E. Holland, M.D.

LEE — William R. Bess Jr., M.D.; Robert J. Brueck, M.D.; Larry P. Garrett, M.D.; Steven E. Levine, M.D.; Marcus McDuffie Moore, M.D.; Rodger W. Shaver, M.D.; Theron T. Knight, M.D.

MADISON — Absent

MANATEE — Julian Giraldo, M.D.; Clyde L. Skene Jr., M.D.

MARION — Henry L. Harrell Jr., M.D.; Douglas R. Murphy, M.D.; William A. Trice, M.D.; Richard B. Van Eldik, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D.

MONROE — Absent

NASSAU — Charles M. Tomlinson, M.D.

OKALOOSA — David R. Arrowsmith, M.D.; William W. Thompson, M.D.

ORANGE — Richard J. Bagby, M.D.; Manuel J. Coto, M.D.; Pedro P. Diaz, M.D.; Wayne L. Godbold, M.D.; Alfred Heydrich, M.D.; Jay M. Hughes, M.D.; Angelo Massaro, M.D.; Joseph G. Matthews, M.D.; Franklin B. McKechnie, M.D.; Louis C. Murray, M.D.; Keith McManos, M.D.; Elizabeth D. Nelson, M.D.; Calvin R. Peters, M.D.; Wallace, M. Philips Jr., M.D.; James F. Richards Jr., M.D.; Philip G. St. Louis, M.D.; Philip N. Styne, M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D.

OSCEOLA — Alonzo J. Logan, M.D.

PALM BEACH — Roberto E. Acosta, M.D.; Joe A. Baker, M.D.; Elizabeth J. Barice, M.D.; McKinley Cheshire, M.D.; Ralph R. Eastridge, M.D.; Demetri P. Falticeni, M.D.; Lee A. Fischer, M.D.; John A. Hildreth, M.D.; Lewis H. Kaminester, M.D.; Catherine Lowe, M.D.; V. A. Marks, M.D.; Mas G. Massoumi, M.D.; Charles L. Moore, M.D.; Gilbert R. Panzer, M.D.; Joseph F. Phillips, M.D.; Robert E. Raborn, M.D.; James F. Smith, M.D.; Joe F. Smith, M.D.; Anthony L. Thebaut, M.D.; Milton R. Tignor, M.D.; Dick L. Van Eldik, M.D.; Pennington R. Wimbush, M.D.

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Ward H. Broadfield, M.D.; Dominick A. Caselnova, M.D.; Carl W. Graves, M.D.; Michael Myers, M.D.; Maynard F. Taylor, M.D.

PINELLAS — Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony P. Garritano, M.D.; William E. Hale, M.D.; James A. Hallock, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris J. Levine, M.D.; Louis J. Michaelos, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; Jack N. Rothman, M.D.; Joseph Turbin, M.D.; Thomas H. West, M.D.; Robert H. Zieburtz, M.D.

POLK — Annette C. Barnes, M.D.; Ray Barnes, M.D.; Francis D. Drake, M.D.; Richard M. Garcia, M.D.; Donald I. Gale, M.D.; John W. Glotfelty, M.D.; David T. Jones, M.D.; Robert B. Peddy, M.D.; Wilton M. Reavis Jr., M.D.; Dale L. Taylor, M.D.; Daniel W. Welch, M.D.

PUTNAM — Absent

ST. LUCIE-OKEECHOBEE — Jack W. Barrett, M.D.; Khalil A. Cassimally, M.D.; Manuel G. Garcia, M.D.

SANTA ROSA — David Bruce Young, M.D.

SARASOTA — William E. Bush, M.D.; John N. Carlson, M.D.; George M. Coggan, M.D.; Kenneth C. Kiehl, M.D.; Robert R. Lastomirsky, M.D.; Charles R. Mathews, M.D.; Franklin H. Pfeiffenberger, M.D.; Karl R. Rolls, M.D.; Vincent Stenger, M.D.; David L. Thomas, M.D.

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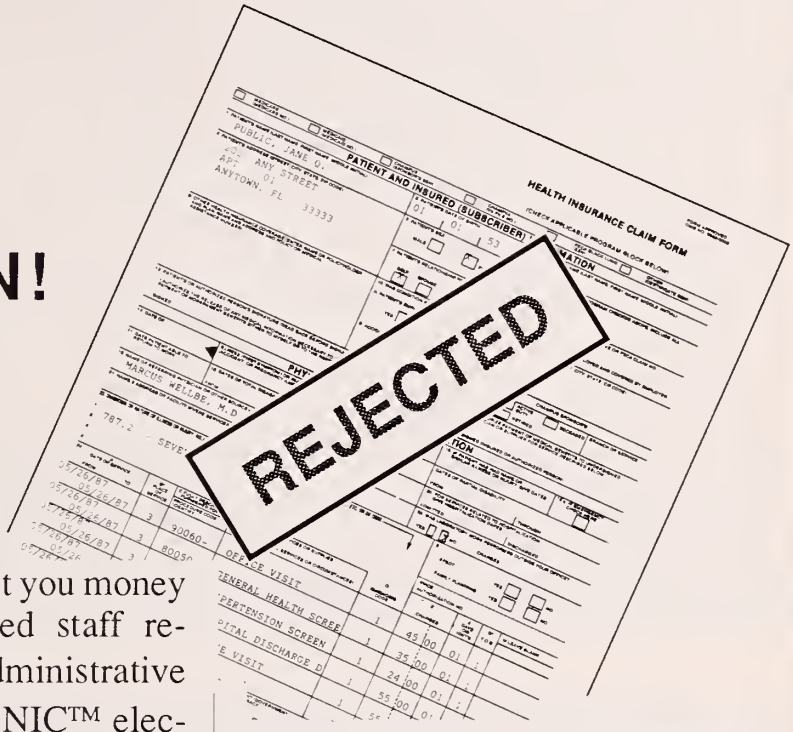
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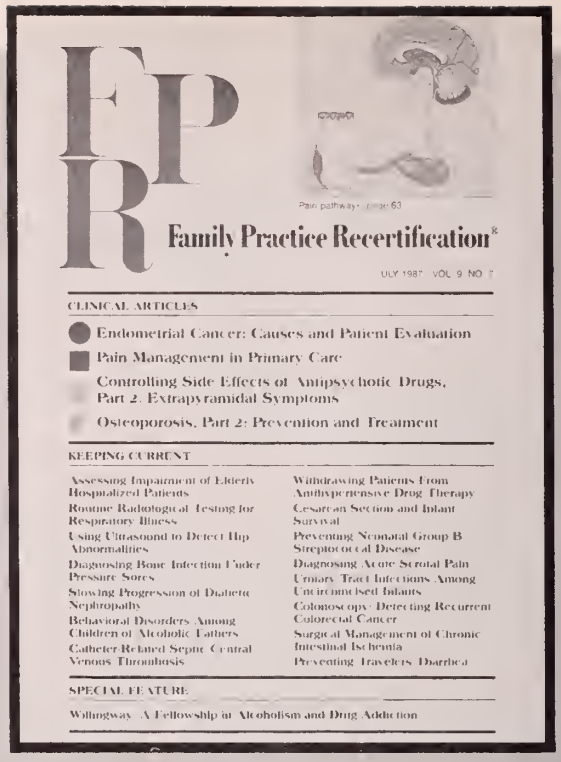
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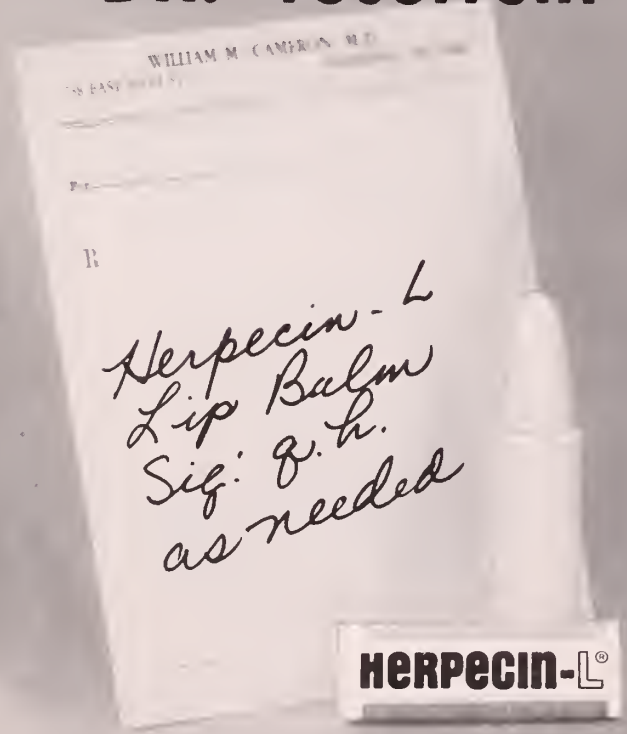
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Group Practice as the Safe Haven for the Beleaguered Private Practitioner

As another fiscal year slams shut, physicians continue to twitch from the intensifying efforts of the government and other payors of health care costs to ratchet down physician control over the practice of medicine. Medicare and insurance companies continue to reduce allowable charges for medical services of physicians. Ponderous, new administrative regulations regarding the "appropriateness of procedures" have been imposed by the Health Care Financing Agency. These bureaucratic actions have been costly for doctors. Initial reports indicate that gross physician income has either fallen or remained fairly stable over the past year while overhead has risen about four percent. Figure 1 depicts the future decay in net physician income that will be experienced if the present situation continues unabated. The ultimate absurdity, at which point we will be working for nothing, occurs in 17 years.

The "cognitive," or technologically-barren doctor, such as the family practitioner and pediatrician, has been financially scarified the most during the past ten years while surgeons, anesthesiologists and radiologists have enjoyed an increase in income that has surpassed inflation. A pall of impending financial extinction cloaks the future of many primary care doctors. Solo practice, traditionally the sanctuary of the individualistic, entrepreneurial family physician, may become his or her cloister of doom within a decade.

The inclement conditions of the past few years have accelerated the growth of group practices. In 1969 only 49,000 physicians practiced in groups; in 1984, 140,000 doctors were members of groups. This figure is equivalent to over one-third of all active, non-federal physicians. Even more impressive is the trend among younger, recent entrants into private practice: 75% of doctors starting practice since 1980 have joined groups. Many reasons exist for this rather startling trend toward group practices among younger doctors: First, start-up costs for establishing a practice are high — much higher than previously when one considers the subdued expectations of future financial reward. The investment in equipment, new furniture, adaptation of an office facility, inventory and the hiring and training of new employees may exceed the first year's net income of many new physicians. Most recent graduates have invested nearly $100,000 for their medical education. Many have borrowed heavily. The average debt of those who owe exceeds $25,000. Many recent graduates are women for whom family concerns are very important. They require regular hours, a secure income, and flexibility in their scheduling that solo practice will frequently not yield.

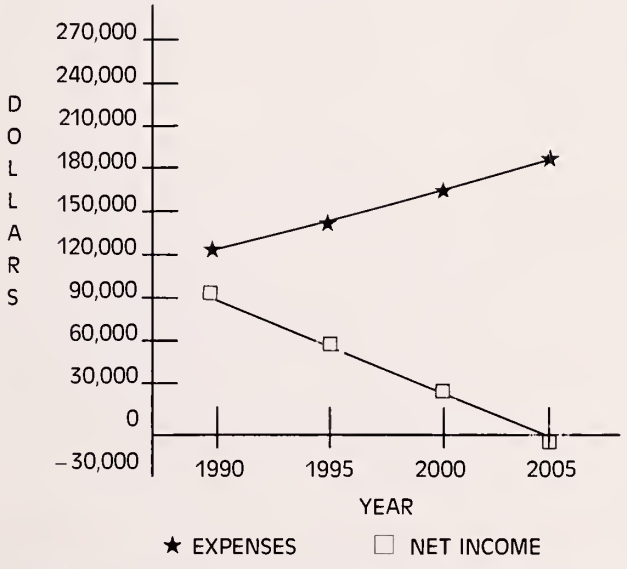


FIGURE 1.— Decay of net income with time assuming a constant gross income and a four percent annual increase in overhead costs.

Table 1.—Income Differences Between Group and Solo Practitioners.

YEAR	1975	1977	1979	1981	1983	1985
SOLO PRACTICE	51.60	56.30	75.80	88.20	100.00	111.10
GROUP PRACTICE	61.10	68.30	80.70	97.20	111.90	112.80
DIFFERENCE	9.50	12.00	4.90	9.00	11.90	1.70
PERCENT	18.4	21.3	6.5	10.2	11.9	1.5

Table 2.—1985 Mean Income Differences Between Group and Solo Practitioners, By Specialty.

SPECIALTY	ALL	GP/FP	INT.MED.	SURG.	RAD.
SOLO PRACTICE	111.5	79.3	106.6	144.7	118.3
GROUP PRACTICE	114.6	76.6	97.1	165.6	155.6
DIFFERENCE	3.1	−2.7	−9.5	20.9	37.3
PERCENT	2.8	−3.4	−8.9	14.4	31.5

Many doctors find the advantages to group, *vis a vis* solo practice, to be multiple and variable. The net income of group practitioners has surpassed that of individual practitioners for the greater part of the past ten years (Table I). The differences in income had averaged about ten percent per year until 1985. The convergence of the net incomes of the two groups in 1985 probably reflects the reduced pay scales offered to doctors who work for HMOs as employees; salaries in such organizations are notoriously low and often begin at the $28,000 to $35,000 level for family practitioners. Nevertheless, large advantages in the annual income of certain types of specialists practicing in groups were seen in 1985 (Table II). Pay differences for surgeon and radiologist group members exceeded those of solo practitioners by 21 to 38 percent! Very small differences in income were reported for pediatricians, family practitioners or general internists; usually the solo practitioner earned slightly more than the group member but the figures are distorted by the HMO data.

The increased earnings for the group practitioner can be ascribed to two conditions. The first is a greater gross income per physician; this is partly attributable to a larger net charge per visit to the individual patient in the group environment. The second is the slightly reduced percentage of overhead in the group practice environment per doctor. Many reasons for these overhead reductions exist. Each doctor averaged fewer employees per physician. Administrative overhead per doctor was also less. Sharing of fixed expenses such as property taxes, some forms of insurance, telephone, billing, computer services, supplies, etc. reduces costs significantly; those savings can be passed onto the participating doctors.

Group practices enjoy other advantages besides an income differential. Perhaps the greatest benefit is the ability to hire an accomplished administrator to attend to the myriad, assorted and sordid details that threaten to exhaust the individual practitioner. This person can attend to the disagreements among physicians and to the managerial unpleasantness associated with employee disputes, grievances, and performance problems. This individual can keep abreast of the changes in the federal and state statutes that relate to the practice of medicine, can organize, establish, monitor and run the in-house accounting system; can govern the accounts receivable; can shop for insurance to optimize the efficiency of dollars spent for liability, health, malpractice, and disability coverage; and can explore technological advances that can increase the efficiency of the administrative facets of medical practice. The administrative details of our practice now consume close to 20% of our time and income-producing activity. A good administrator can free physicians to perform at maximal efficiency — by providing excellent care to patients in the most efficient and technologically advanced fashion possible. A physician in a group can save 10-20 percent of his or her time by the presence of an administrator who can convert that time to greater productivity or to more free time available for outside activities. If twenty physicians can band together to pay an administrator $80,000 per year to permit each of them to increase their productivity only ten percent then they will enjoy a cumulative return of 250% on their investment each year.

Group practices share other opportunities that the solo physician cannot enjoy. Long term strategic planning for the future medical needs of the community in which we practice will be mandatory if we are to maximize our economic survival. Very few, if any of us, want to attend to such planning. It is foreign to us, ridden with details and projectional statistics that bore the majority of us, frought with uncertainty, and outrageously time-consuming. However, in

this day of severe competition for patients and economic uncertainty, strategic and tactical planning, long-range and short-range, are necessities rather than luxuries. How many of us have given our practices the in-depth futuristic attention that they require?

The successful practitioners in the future will be individuals or groups of individuals who can distinguish themselves by technological freshness and awareness and who can project their avant-garde knowledge and capabilities to the surrounding community in which they practice. This characteristic

The successful practitioners in the future will be individuals or groups of individuals who can distinguish themselves by technological freshness and awareness and who can project their avant-garde knowledge and capabilities to the surrounding community in which they practice.

assumes two attributes: the financial soundness to afford or to raise the capital required to purchase technology in a timely manner and the establishment of a marketing program that can inform the community of these capabilities. As medical technology becomes more expensive, the individual doctor will be excluded from competition — unless the hospital provides it for him. Hospitals, however, will be limited in their capital investments by law and by their own needs to provide for the acutely ill. Most doctors will be conducting their practices in an outpatient setting. Their capital requirements will be satisfied by a consortium of doctors, groups, or joint ventures between hospitals and groups. Individuals will be excluded unless they can join the consortium.

The group practice concept, unfortunately, will not be the salvation of private, fee-for-service medicine in America. It has its limitations.

Marketing of medical services will, unfortunately, become a greater reality in the future, hypercompetitive environment. An effective marketing program in the Miami area will cost about $1,000,000 — a sum far beyond the capabilities of the individual doctor. Large groups of forty or more physicians can utilize their combined financial might to mount a successful marketing program — if one is needed to sustain their place in the medical community.

"Managed care" is the current response of the business community to excess health care costs. Employers wish to establish PPOs and other contractual arrangements with physicians to obtain care at the lowest possible cost for their employees. The individual practitioner confronts the same choices as did the small retailer or grocery store vendor of a generation ago. Fee discounts will have to be granted or the physician will have to tolerate loss of patient population. Groups can respond to the competitive environment better than can the individual doctor: groups can provide a more comprehensive list of services because of the mixture of their physician specialty capability and because of the allegiance and control of a greater share of the local patient population.

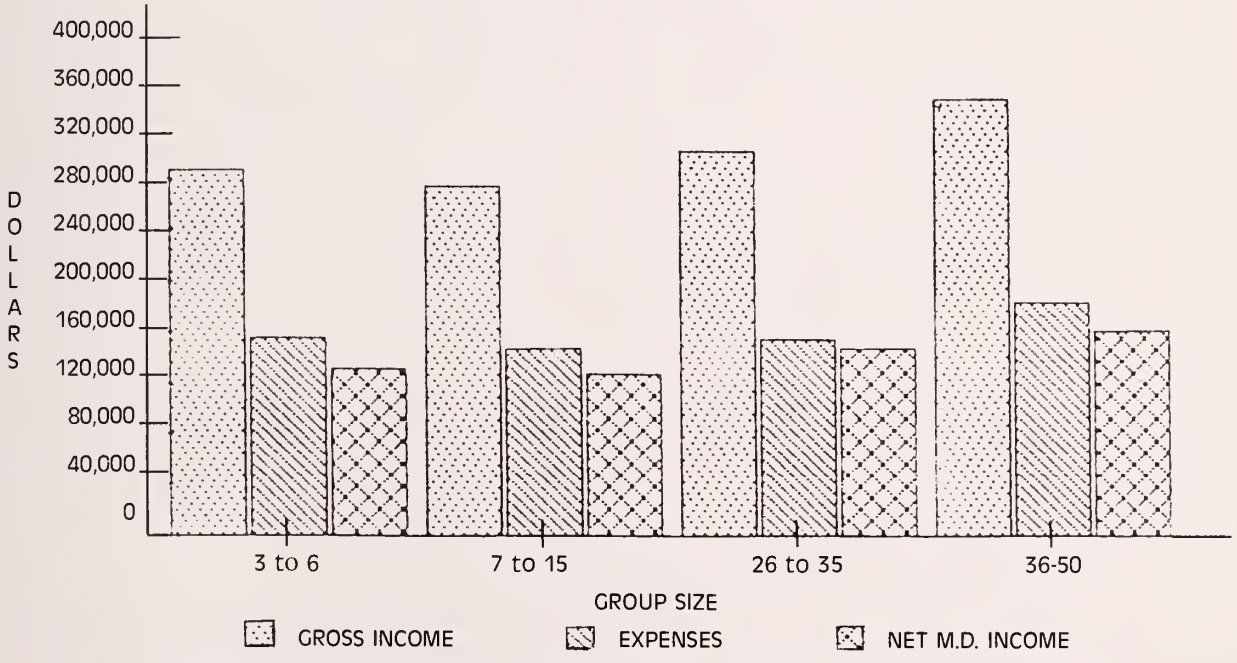


Fig. 2.—Mean values for gross income, total expenses, and net income per physician member of selected sized USA groups, 1986. Size of group refers to the number of physician members. (Adapted from "The Cost and Production Survey Report," Medical Group Management Association, 1987).

Groups will not be subject to the financial "blackmail" that can be imposed by employers or insurance companies as will be individual doctors.

What about the patient in the group vs. individual practitioner discussion? Health care consumer surveys indicate very small preference between care given by groups versus that given by solo practitioners. In general, the elderly prefer solo physicians but the younger population prefers care given by the group. The differences are very small when statistically analyzed. The public has adapted well to either form of health care. Certainly no data exist that would distinguish either form of health care provider organization on the basis of quality of care. The patient is equally well served by either form of medical care.

The group practice concept, unfortunately, will not be the salvation of private, fee-for-service medicine in America. It has its limitations. First, its economies of scale plateau after the group reaches a size of 35-50 physicians (Figure 2). Very large groups, such as those in academic institutions, can transform themselves into administrative brontosauri that escape control by human society. Most of us have been employed by such institutions during our training and academic careers. Groups are not the sacred respositories of the magical formula that will resolve the needs of the indigent or the medically uninsured. They are subject to the same financial constraints imposed by government and other regulatory bodies, payors or administrative busy-bodies who wish to interfere with the provision of good medical care. Furthermore, groups will not appeal to all physicians. Doctors are a very independent lot of people and most have difficulty adapting to the structured environment and lack of control of their destiny that the group may impose.

The obituary of solo, private practice has been prematurely published and lamented at several points in twentieth century American history. No doubt this article will err in its prediction of the demise of the individual American doctor who wishes to practice according to his or her own principles and style. Hopefully medicine will always attract some of those individuals who exude the singularity of spirit and the determination to pursue the care of the sick in a manner that they find uniquely beneficial to the ill folk for whom they care as well as to themselves. It is regrettable to reflect upon the future legions of American medical practitioners as a faceless throng of corporate homogenates. Unfortunately, the trend of the current forces weighing upon medicine will deprive the future corps of American doctors of those opportunities for individual expression and style that has been the privilege of the physician in Western society for over 2500 years.

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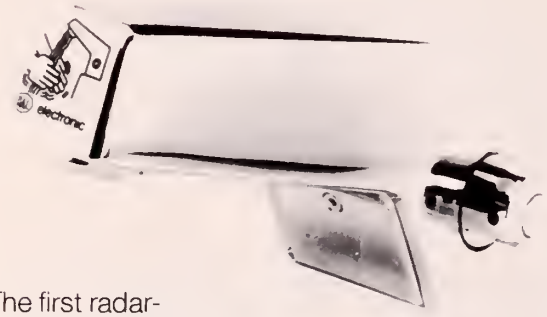
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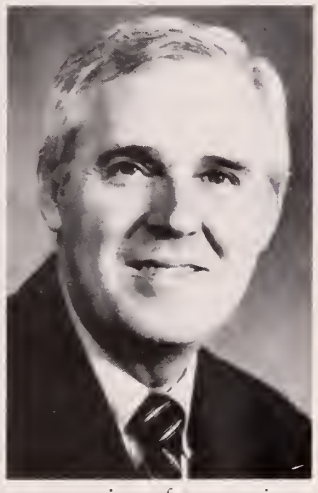
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☐ NOTES & NEWS

Dr. Dockery Named President of Southern Medical Association



J. Lee Dockery, M.D., executive associate dean and professor of obstetrics and gynecology at the University of Florida College of Medicine, was elected president of the Southern Medical Association at its 81st Annual Scientific Assembly held in San Antonio, Texas in November.

The Southern Medical Association is a 50,000-member voluntary association of physicians whose purpose is to foster scientific medicine. Since joining the Southern Medical Association in 1965, Dr. Dockery has served the association in several capacities including associate councilor, councilor from Florida, chairman of the council and vice president.

Dr. Dockery also is the secretary of District IV and a fellow of the American College of Obstetricians and Gynecologists, a diplomate of the American Board of Obstetricians and Gynecologists, and past president of the Florida Obstetric and Gynecologic Society. He also is past president of the Florida Medical Association and currently a member of its Board of Governors.

In addition, Dr. Dockery is an elected member of the Council on Medical Education by the House of Delegates of the American Medical Association and the Accreditation Council on Graduate Medical Education. He is a member of the South Atlantic Association of Obstetricians and Gynecologists and a delegate from Florida to the American Medical Association.

Dr. Seckinger Re-elected Governor of College of American Pathologists

Daniel Seckinger, M.D., of Miami, was recently re-elected to a three year term as a Governor of the College of American Pathologists (CAP). He was sworn into office at the Fall 1987 Meeting of the CAP and the American Society of Clinical Pathologists, held in New Orleans.

Dr. Seckinger has served the CAP as chairman of the Council on Quality Assurance, the Instrumentation Resource Committee, and the Reference Committee in the CAP House of Delegates. He has also served as a vice chairman and member of numerous other CAP committees and councils.

Dr. Seckinger is currently Director of Laboratories at Cedars Medical Center, Miami, and South Shore Hospital, Miami Beach; and Clinical Professor at the University of Miami School of Medicine.

Dr. Seckinger received both his M.D. and his undergraduate degrees from George Washington University, Washington, D.C., completing his studies in 1954.

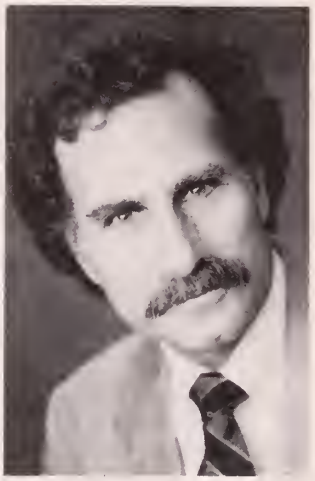
Blood Bank President Heads National Organization

Paul J. Schmidt, M.D., became the 40th president of the American Association of Blood Banks (AABB) at the group's annual meeting which took place in Orlando, November 7-12. Dr. Schmidt is president of Southwest Florida Blood Bank in Tampa and a professor of pathology at the University of South Florida.

The American Association of Blood Banks is the largest professional association devoted to transfusion medicine and blood banking in the world with more than 7,500 individual and 2,500 institutional members. Southwest Florida Blood Bank was one of the founding members of the AABB in 1947.

Before coming to Tampa in 1974, Dr. Schmidt was chief of the Blood Bank Department for the National Institutes of Health in Bethesda, Md. and served as clinical professor of pathology at Georgetown University, Schools of Medicine and Dentistry in Washington, D.C. He is a recipient of the AABB's Emily Cooley Memorial Award given in recognition of outstanding scientific and teaching abilities. Dr. Schmidt is also the co-editor of the AABB's 12th edition (1987) of "Standards for Blood Banking and Transfusion Services" which is recognized by the Joint Commission on Accreditation of Healthcare Organizations as providing the criteria for transfusion therapy in the U.S. and has been translated into four languages.

ACEP Elects Board Member



Jay W. Edelberg, M.D., FACEP, director of the emergency medicine department at Baptist Medical Center and president and chairman of the board of directors of Emergency Physicians, Inc., both in Jacksonville, was elected November 1 to the Board of Directors of the American College of Emergency Physicians (ACEP). The ACEP Council, the representative body of the College, elected him to the board during ACEP's annual Scientific Assembly.

Dr. Edelberg is also on the voluntary clinical faculty of the department of emergency medicine and the department of oral and maxillofacial surgery at the University Hospital of Jacksonville.

He is a member of the Jacksonville Fire and Rescue Board of Fire Surgeons, as well as a member of the Duval County Medical Society's Emergency Medical Services Committee.

An ACEP member since 1976, Dr. Edelberg has participated in numerous committees. He is past president of ACEP's Florida Chapter.

Dr. Edelberg is an appointed member of the American heart Association's Advanced Life Support (ACLS) National Faculty. He has served on the State of Florida's American Heart Association CPR-ECC Council for 8 years and was chairman of that Council for three years.

He is a frequent lecturer at local, state, and national meetings on subjects such as "Emergency Management of Trauma Patients," "Hazardous Materials Management," Acute Respiratory Distress," and managed care plans (HMOs and PPOs).

DEAN'S MESSAGE

Ethical, Moral and Legal Issues Surrounding AIDS

Newspaper and magazine writers report extensively on the AIDS crisis, but tend to focus on either the tragic lives of individual sufferers or on numbers and statistics which portend dire consequences for the future. All of this is compelling reading; however, the public is rarely exposed to the ethical-moral-legal issues surrounding AIDS. There is a tendency on the part of the public, government, and even physicians, to avoid serious discussion and subsequent implementation of policy concerning these issues.

AIDS opens a whole new realm of ethics and legalities within the medical profession and within society in general. These ethical and legal concerns must be met head-on in a no-nonsense, nonpolitical and nondiscriminatory manner. Physicians must be active participants in these discussions and policy decisions because it is the medical community that on a daily basis grapples with the ethical concerns of treating patients. Before policies and laws can be instituted, the medical community needs to enter into a consensus on key ethical issues concerning AIDS.

According to an informal survey conducted in September by the University of Miami School of Medicine's student newspaper, *The Fovea*, one area where this consensus is notably absent relates to whether or not there should be mandatory testing of hospital patients. Both faculty and fourth year students were evenly divided on this issue.

In favor of mandatory testing, one could argue that the knowledge of a patient's positivity for HIV affords the health care worker some measure of protection by allowing him or her to undertake safety measures. While this argument retains some validity, it is in practice flawed.

Primarily, indications in a patient's medical chart that he/she has tested negative may lend a false sense of security to the health care provider. Someone exposed to the HIV virus may not convert for upwards to a year or even more. During this time, a person may still be able to transmit the virus to a careless health care worker who becomes lax in his or her technique. All health care workers must assume that all patients are potential carriers and treat them with the necessary precautions. In fact, the CDC has recently set forth guidelines for the treatment of all patients in response to the finding that three unprotected health care workers became infected after exposure to (copious) amounts of blood from HIV infected patients.

Secondary arguments against mandatory testing include the potential for abuse of this highly stigmatized information and the fact that the funds allocated for testing can best be used for research, treatment, and education. Therefore, it is evident that mandatory testing of all hospital patients is not in the best interest of the patient nor the health care provider.

The abuse of HIV test information can be manifested in several ways. Foremost in the health care atmosphere is that this information may encourage the denial of care to an infected individual by medical personnel. A *Fovea* survey finding that is a cause for concern is that 15% of students said that they have refused to treat a patient who has or is suspected of having AIDS versus 4% of the faculty. Some have attributed this finding to a more socially conservative student body. While it may be true that

students and new physicians are more apt to adopt the viewpoints of the lay citizen due to their recent matriculation into the society of physicians, a deeper analysis needs to be made.

When third year clerks first enter the ward, they are generally forced to learn technique by example. Many times they are shown a procedure only once or twice, and so may be apprehensive about attempting newly learned techniques on AIDS patients. This may not be due to a deep-seated prejudice against people with AIDS, but is symptomatic of a lack of confidence in their abilities due to a lack of experience. Perhaps medical students need better training in the performance of risky techniques before they enter their clerkships.

The finding that is most disturbing is in the study of 258 physicians-in-training. This study of New York City hospitals found that one quarter believed that it was not unethical to refuse care to people infected with the HIV virus. The excuse that is heard frequently for the refusal to treat HIV infected individuals is that since AIDS is a fatal disease, physicians should be allowed to protect themselves as much as they feel necessary. Granted, physicians are human and subject to the same fears that the public in general feel, but there is no room in this epidemic for irrational fears which are the cause for the small but increasing numbers of doctors refusing to care for HIV carriers. Perhaps the discrepancy between established physicians and physicians-in-training in their willingness to treat AIDS patients is due to the fact that newcomers to medicine have never really been faced with incurable infectious diseases as have older physicians who entered medicine before many of the miracle cures were put to use. This does not mitigate the fact that a physician's denial of health care is unwarranted in light of the evidence that the HIV virus is rarely transmitted to health care workers. Most importantly, these physicians' arbitrary denial of care fuels that public's hysteria and justifies discrimination in other quarters of society. These physicians' actions can be interpreted as a form of discrimination against homosexuals, blacks, and the poverty stricken. The denial of care to any patient is indisputably unethical.

The majority of physicians have responded to the AIDS crisis with sense and compassion. It is the duty of this majority to ensure that the number of physicians denying care to HIV infected individuals decreases and preferably disappears. Physicians must lead the way in the enlightenment of society and the implementation of public policies concerning AIDS issues.

Terry Adirim
Sophomore Medical Student
University of Miami
School of Medicine

ENCORES!

What's Wrong With the FMA Convention

Recently I had occasion to attend the annual FMA Convention as a delegate from Volusia County. This is the fifth time I have been to the FMA Convention and I am amazed that I am still learning about how the FMA Convention works and how the FMA itself works.

Needless to say, the FMA today is under a great deal of fire from its membership. Certainly, no one is more aware of this than the staff members of the FMA and the elected officers who make up the FMA leadership. The FMA leadership has been on the forefront of the firing line as it has had to take the brunt of criticism from the membership for its supposed failure to solve the malpractice crisis. Of course, the FMA leadership cannot solve the malpractice crisis without the actions of the legislature, which often is not in accordance with FMA wishes.

I have been a supporter of the FMA and will continue to be a supporter of the FMA. I fully believe that if the FMA did not work on behalf of its members, there would be no one working on our behalf and we would be adrift in a sea of hostility. We would take wheatever scraps were thrown to us from the legislature. The legislature would be heavily lobbied by trial attorneys and other factions which certainly do not have the interest of the physicians at heart. However, this editorial is to offer some constructive criticism on how at least the FMA Convention could be changed to hopefully offer a better format and a more efficient mode of operation.

For those who are not familiar with the FMA Convention and how it works, let me explain that the House of Delegates meets on the opening day and then various reference committees are set up to hear discussions and to come up with recommendations to the House of Delegates which are then voted on the last two days of the convention. Obviously, the work of the reference committees is very important as this is where many of the matters that are vital to members of the FMA are discussed and recommendations are made. The last two meetings of the House of Delegates are then used to hear the recommendations and to vote on them.

One of the recommendations I would most strongly endorse is that the reports from the various reference committees do not need to be read verbatim to the membership. Some of the reports are very long and contain material that is extemporaneous and is useless in arriving at a final decision. I have sat through the reference committees' reports which have gone on ad infinitum at times and become bored,

which has made it more difficult to get down to the meat of the matter when various resolutions are offered.

Hopefully, all doctors can read and those who wish to read the 3-4 paragraphs in which the members of the committees are thanked should certainly be free to do so. What should be done by the reference committees is to see that the resolutions which are discussed in their deliberations be presented to the delegates before the meetings and the resolutions then are brought up, discussed and voted up or down. This in itself would save much time and would make business more efficient and easier to conduct. It also would not leave a horde of physicians anxious to run to the door on Sunday at 11 o'clock as they plow through the final three pages of the last reference committee.

Secondly, I would respectfully submit that the mode of elections for the FMA officers be changed. I think that one of the loudest criticisms that we hear from physicians across the state is that the FMA is "the old guard." I am not quite sure what the old guard represents, but it appears to represent entrenched elements of the FMA leadership who have gotten themselves to the top and have stayed there indefinitely.

Unfortunately, while I think that the leaders of the FMA have represented good, honorable and conscientious people, I do think that there may be some element of truth in the criticism which must be addressed. Presently, it seems that there is no length to the terms of office for various positions except for the president. Consequently, a person can be elected to an office such as the secretary or treasurer and may stay there indefinitely. Of course, anyone who wishes to answer this criticism can say every position is open and must be elected every year. That is true, but the fact of the matter is that once you are in an elected position it is much easier to get elected after that. I feel that the FMA should look at limiting the terms of office for elected positions other than the presidency. I think that this would encourage people who wish to move up. It would also discourage those who want to stay in a particular position for years. I think that it is time the FMA begins to encourage new leadership, a transition of leadership and move in that direction.

However, I also would suggest that the presidency of the FMA be changed so as to allow a person to remain in that position for longer than one year if he were so inclined and if he were reelected. I have not gone back and read the bylaws on this, but I do not think there has ever been a president to remain more than one year. However, with the times that we now live in, a president is usually only learning his job, getting familiar with the public relations and getting comfortable after one year. I think that the office of president should be allowed to serve two terms if he were to be elected. I realize that not many people would want to serve two terms, as to be a president of the FMA means a virtual secession of your practice, but perhaps there are people who would fit that category and the FMA could utilize the talents that they had gained over that one year.

Lastly, I think it is time for the FMA Convention to give thoughts to holding it at another location. This certainly is not unique with this editorial, as I think the sentiment at this year's convention was clear that the convention be held some place other than the Diplomat Hotel in the future. I would strongly recommend that the FMA staff make whatever provision is needed to move it to another location more central in the state and adequate to handle a convention of this size.

I make the foregoing suggestions knowing full well that there may be others who disagree with me, but I think it is time to implement these suggestions and to answer some of the criticism that has been directed to the FMA.

H. Frank Farmer Jr., M.D., Ph.D
Historical Editor

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Do You Have Time For the FMA?

I had the privilege of attending the annual Florida Medical Association (FMA) meetings in Hollywood, Florida recently. The FMA sessions at the Diplomat Hotel resembled a hornet's nest. Almost fifty new resolutions were presented, debated, and voted upon by hundreds of FMA physicians from around the state. Offices were being sought by the FMA's future leadership. A vast array of medical-political speakers and seminars were being conducted in every banquet hall. In the evenings the bars would teem with more personal expressions of taste or distaste on particular volatile issues. The restaurants would rattle with chatter on differences of practice in Dade vs. Polk, or partnership or corporation.

I was overwhelmed with pride to be following in the paths of such outspoken and concerned men and women. I thought of the ancestry of medical leadership which created the opportunities and challenges which now rested on my lap — that was a demanding thought! I sat in the lobby and mused at the notion of the infinitesimally small role each one of us plays. This role would be no more recognized than the reflection on the wine in my glass — but in concert, the possibilities seemed awesome.

Marc Apple, Robert Blais, Lisa Kim and I attended these meetings as representatives from the University of Miami to the FMA Medical Student Section Governing Council. Three delegates (and one alter-

nate delegate) from each Florida medical school serve on this Board to represent the interests of medical students. Your voice was heard on a variety of issues brought before the FMA. It was a pleasant surprise to me to find how receptive our elder colleagues were to the students' heartfelt concerns. Our senior physician brothers and sisters very definitely and adamantly conveyed to us the urgency I am passing on to you in this article.

So why is it that we are here at the University of Miami studying medicine anyway? Toiling each day with a new and revised scheme to combat academic brutality is not commonly cited as a definition for pleasure. Wracking as many neurons as one can muster for as long a period as one can withstand would not seem a logical endeavor for most people. For many of us it must be the hope which fuels our passion for this torture. Sure I get high on the academic challenge which seeks to dethrone my pride. Sure the boundaries and interplay of science provide occasion for an intellectual repast, Sure, the camaraderie we share must be tighter knit than that of other professions. However, I believe it is a foundation of hope that brought most of us here.

What do I mean by hope? I mean that some day I hope to express myself in my career — not to fulfill someone else's idea of what that expression should be. I hope for relative autonomy and freedom to exercise my judgments and choices within the confines of our profession based on the thousands of hours of preparation which I will have accrued — not incarceration by the opinions of bureaucrats and lawmakers, most of whom will have accrued zero hours in the practice of medicine. I hope to provide for loved ones a standard of living based on a compensation that is strongly determined by influences of a free market, just like 90% of the rest of the economy upon which this country has flourished for over two centuries — not arbitrary compensation determined by politicians completely alien to the unique tangle of each economic locale. This paragraph is far too miniscule to represent threatened hopes for prospective physicians. The point, however, is sharp.

Take a good look at this "hope foundation," and realize upon what you are basing your consuming decision to endure medical education. Is this foundation being buttressed with the mortar of medicine's richest resources, with the reinforcements of a government laissez-faire policy balanced with reasonable protection from self-interested and starving sharks, and with the struts of an informed society protecting its basic need for an adquate standard of health care?

If you are convinced that the answer to this question has affirmative content, I would suggest that you wake up soon. There is no more time for an ostrich mentality. Our profession is pleading with you to disrobe yourselves of the garments of complacency. Rip off the blindfolds and dive into the midst of a profession at the crossroads. It would be for your very own sake, for the sake of the "hope foundation" upon which your decision to enter medicine lies.

If this warning may seem a bit too alarming, the scenario a bit exaggerated, the haste a bit presumptive, then what I exhort you to do is read your journals and speak to practicing physicians. In fact this described warning, this scenario and this haste are vastly understated.

Time and again we heard that now is not too early to begin gathering experience in medical politics. Tad Fisher, a representative from the FMA was a guest speaker at one of our Governing Council meetings. He eloquently spoke to us on the very urgency that our profession faces. "To begin now to train medical students to be versed in politics is to begin too late," he explained.

I am reasonably well informed of different opportunities that medical students can take advantage of during their training years. Few such opportunities, however, could beg your attention more convincingly than participation in the battles, and the progress of the American Medical Association. Granted, it is but one avenue you should consider. However, to become engaged in the construction of a retaining wall which could buttress that very "hope foundation" upon which we have decided to build our careers is one critical consideration. I have personally found that the Medical Student Section of the FMA is a way to influence our professional futures. I have not begun to enumerate the resources and channels that the FMA MSS has available to you, but only the necessity to pursue these opportunities. Your next step I hope is obvious.

For information on joining and becoming involved in our U of M Chapter, contact Marc Apple, sophomore. No experience or knowledge is required, just a willingness to become informed.

Please refer to articles by Robert Blaise and Marc Apple on specific issues brought up at recent FMA meetings.

Peter Cole
Miami

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FLMD 1087

Auxiliary Liaison Editor — Mrs. Charles (Lynn) Moore

Confluence — From the Perspective of a (Formerly) Reluctant Participant

This past summer flew by far too quickly. The sultry, languid days that seemed to pass at a snail's pace when I was a child have quickened exponentially with each passing year of my adulthood. To give my age as "late baby-boomerish" is to say that the summer of '87 was a blur in time! What made this period all the more frantic was the nagging knowledge that I was supposed to be doing something toward my upcoming tenure as president-elect and president of my county's medical auxiliary. Equally annoying was the fact that I didn't know exactly what "something" I was supposed to be doing! Therefore, in the best tradition of all the Scarlett O'Hara's of this world, I simply said, "Tomorrow is another day; I'll think about it then." "Then", however, turned out to be September, and the "somethings" were, for the most part, "nothings."

At this point, resignation from my post seemed quite a viable alternative, Enter - an opportunity to attend Confluence in Chicago. Oh, there were any number of excuses why I shouldn't — couldn't — attend. But I did attend; and the experience was worth every minute of the time I spent worrying about how my carpools were being handled back in Pensacola.

The word "confluence" means "a coming together" — in this case, not only of people but, more importantly, of ideas. The chance to get to know capable, intelligent women from around the country; to share opinions and experiences; to listen and learn — each was an opportunity for enrichment. To say that I was broadened by these experiences is an understatement. I was challenged, encouraged, made to examine issues, and forced to discard preconceived opinions. In the process, I found direction for my own term of office; and now, every "nothing" of September has become a "something" filling two notebooks.

To each of you who read this article, I can only stress that the opportunity to attend Confluence is worth a term as a county or state officer and certainly worth several summers of discontent. If you are offered the chance, go for it; learn from it; use it; and then come back and make Florida a better place for it!

Mrs. Kenneth (Emily) Hill
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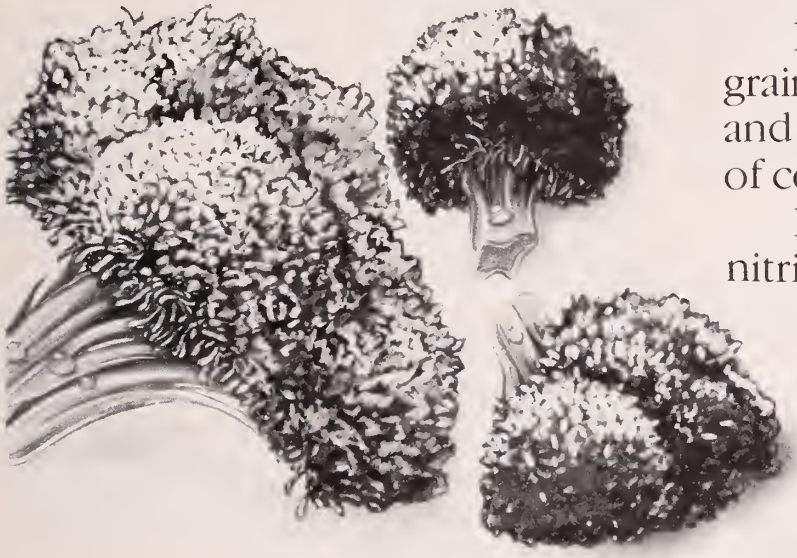
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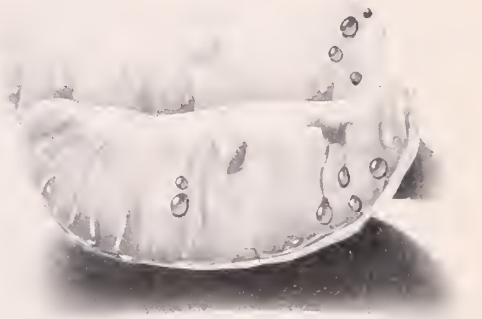
Foods related to lowering the risk of cancer of the larynx and esophagus all have high amounts of carotene, a form of Vitamin A which is in cantaloupes, peaches, broccoli, spinach, all dark green leafy vegetables, sweet potatoes, carrots, pumpkin, winter squash and tomatoes, citrus fruits and brussels sprouts.



Foods that may help reduce the risk of gastrointestinal and respiratory tract cancer are cabbage, broccoli, brussels sprouts, kohlrabi, cauliflower.

Fruits, vegetables, and whole-grain cereals such as oatmeal, bran and wheat may help lower the risk of colorectal cancer.

Foods high in fats, salt- or nitrite-cured foods like ham, and



fish and types of sausages smoked by traditional methods should be eaten in moderation.



Be moderate in consumption of alcohol also.

A good rule of thumb is cut down on fat and don't be fat.

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ACLS Course, January 8 - 10, Ormond Beach, Holiday Inn, Contact: Patricia Dranginis, D.O., (305) 672-4161, ext. 1500

Chest Pain - The Great Mimic, January 9, Mt. Sinai Med. Ctr., Miami Beach. Contact: Esther Cohen, (305) 534-2916.

Advanced Vitreoretinal Surgery Course, January 14-16, Sarasota. Contact: Miguel Arcacha, M.D. (813) 952-0900.

Workshop in Clinical Hypnosis, January 14-17, Las Palmas Hotel, Orlando. Contact: Charles B. Mutter, M.D. (305) 547-2000.

33rd Annual Cardiovascular Seminar, January 15-16, St. Petersburg Hilton, St. Petersburg. Contact: Melissa S. Crater, (813) 867-5000.

Conference on Addictive Illnesses, January 16, Tampa Airport Hilton, Contact: Fred W. Frick, M.D., 1-800-368-6222.

Advances in Neurology, January 17-23, South Seas Plantation, Captiva Island, Ft. Myers. Contact: Millie F. Walden (904) 374-6058.

Magnetic Resonance Imaging, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Lipo Injection Technique, January 19, 1988, University of Miami, Miami. Contact: Larry D. Garland, M.D. (305) 547-4477.

20th Annual Postgraduate Seminar in Pediatric and Adult Urology, January 21-23, Doral Beach Hotel, Miami Beach. Contact: Charles Lynn, M.D. (305) 547-6596.

USF Contact Lens Course, January 22-23, Lincoln Hotel. Tampa. Contact: Charles Slonim, M.D. (813) 974-4360.

Drug Therapies in Diabetes Management, January 23, Hyatt Regency, Tampa. Contact: John Malone, M.D. (813) 974-4360.

5th Annual Doctor's Hospital Winter Seminar, December 23-30, Vail, Colorado. Contact: George T. Venis, M.D. (305) 856-6121.

Problem Oriented Approach to Vitreous Surgery, January 25-27, Biscayne Bay Marriott, Key Biscayne. Contact: Karl Olsen, M.D., University of Miami, Dept. of Ophthalmology (305) 326-6031.

Magnetic Resonance Imaging, January 25-28, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

20th Post Convention Seminar, January 25-28, Acapulco Princess Hotel, Acapulco. Contact: Charles Lynne, M.D. (305) 547-6596.

12th Annual Halifax Pastoral Care Institute, January 28-30, Halifax Hospital, Daytona Beach. Contact: Chaplain James Smith, (904) 254-4138.

2nd Annual Conference on Ethical Issues in Health Care, Orlando Marriott Hotel. Contact: Grace Wagner (904) 392-6428.

Arrhythmias: Interpretation, Diagnosis and Management, January 29-30, Bahia Mar Hotel, Ft. Lauderdale. Contact: Deborah Wilderson 1-800-421-3756.

Vail Conference in Anesthesiology, January 30-February 6, Vail, Colorado. Contact: Brian Craythorne, M.D. (305) 547-6411.

FEBRUARY

13th Annual Review and Recent Practical Advances in Pathology, January 31 through February 5, Fountainbleu Hotel, Miami Beach. Contact: Marie Valdes-Dapena, M.D. (305) 549-6437.

Current Concepts in Cardiovascular Disease, February 1-5, Buena Vista Palace Hotel, Orlando. Contact: Clarence Shub, M.D. (507) 284-2511.

Vail Symposium in Intensive Care, February 6-13. Vail, Colorado. Contact: Brian Craythorne, M.D. (305) 547-6411.

Current Clinical Concepts in Reproductive Endocrinology and Perinatology, February 8-10, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

13th Annual Review and Recent Practical Advances in Pathology February 1-5, Miami Beach, Fontainbleau Hotel, Contact: Marie Valdes-Dapena, M.D., (305) 549-6437.

Current Concepts in Cardiovascular Disease February 1-5, Orlando, Palace Hotel, Contact: Clarence Shub, M.D., (507) 284-2511.

Neurological Update 1988 February 3-7, Bal Harbour, Sheraton Bal Harbour, Contact: Gloria Allington, (305) 547-6716.

Symposium in Intensive Care February 6-13, Vail, Colorado, Contact: Brian Craythorne, M.D., (305) 547-6411.

Current Clinical Concepts in Reproductive Endocrinology and Perinatology, February 8 - 10, West Palm Beach, Good Samaritan Hospital, Contact; Laura Lyons, (305) 650-6236.

20th Miami Winter Symposium, February 8-12, Hyatt Regency, Miami. Contact: W.J. Whelan, M.D., University of Miami, Dept. of Biochemistry (305) 547-6265.

Risk Factors for the Development of Skin Cancer and its Treatment, February 9, University of Miami, Miami. Contact: Larry D. Garland, M.D. (305) 547-4477.

Cardiology at Walt Disney World, February 11-14, Contemporary Resort Hotel, Lake Buena Vista. Contact: Scott Greenwood, M.D. (305) 843-1330.

14th Annual Fred J. Woods Lecture Series, February 12-13, St. Josephs Hospital, Tampa. Contact: Ralph Jensen, M.D. (813) 877-3682.

Alcohol and Substance Abuse, Miami Airport Hotel, Miami. Contact: Raphael S. Good, M.D. (305) 549-7661.

Magnetic Resonance Imaging, February 15-19, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Conference on the Beach, February 15-20, Holiday Inn Surfside, Daytona Beach. Contact: William G. Tomson, M.D. (904) 254-4167.

Special Topics in Diabetes Management, February 16, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Reproductive Organs Abnormalities Symposium, February 17-20, Vail, Colorado. Contact: James Ingram, M.D. (813) 974-2088.

Sarasota Vitreoretinal Update Course, February 18-20, Colony Beach Resort, Longboat Key. Contact: James Kingham, M.D. (813) 921-5335.

10th Annual Pulmonary Winter Course, February 18-21, Contemporary Hotel, Lake Buena Vista. Contact: Richard T. Doggett (904) 743-2933.

Pediatrics for the Practitioner: Update on Pulmonary Diseases, Sheraton Tampa East, Tampa. Contact: Herbert H. Pomerance, M.D. (813) 974-4214.

Dementia: Current Research and Clinical Aspects, Radisson Plaza Hotel, Orlando. Contact: Eric Pfeiffer, M.D. (813) 974-4355.

Health Care for the Elderly, February 19-20, Radisson Hotel, Orlando. Contact: Eric Pfeiffer, M.D., USF Med. Center (813) 974-4355.

Pediatric Dermatology CME Tour, February 19-March 7, India. Contact: Mr. Frank Martin 1-800-243-5030

Eyelid Surgery: A Basic Course for the Practicing Physician, February 20, USF College of Med., Tampa. Contact: J. Justin Older, M.D. (813) 971-3846.

Radiology in Seville, February 20-27, Seville, Spain. Contact: Lucy R. Kelley (305) 674-2681.

Neuroradiology Seminar, Radisson Plaza Hotel, Orlando. Contact: Rick D. Mace (305) 897-1944

Breast and Thyroid Surgery: Current Controversies and Management, February 21-23, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

15th Annual Symposium in Pediatric Nephrology, February 21-25, Sheraton Bal Harbour Hotel, Miami Beach. Contact: Pearl Seidler (305) 549-6726.

Internal Medicine 1988, February 21-26, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bocles, M.D. (305) 547-6063.

Magnetic Resonance Imaging, February 22-28, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Basic Trauma Life Support Provider Course, USF College of Med., Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

February Course in Electrocardiography, February 29-March 2, Marriott Hotel, Boca Raton. Contact: Jules Constant, M.D. Cardiac Study Fund, Box 114, Hiler Branch, Buffalo, NY 14223 (716) 836-5172.

MARCH

20th Teaching Conference in Clinical Cardiology, March 2-5, Sheraton Bal Harbour, Bal Harbour. Contact: Michael S. Gordon, M.D., Ph.D., University of Miami (305) 547-6716.

Mid-Winter Seminar in OB/GYN, March 3-5, Don CeSar Resort, St. Petersburg. Contact: James Ingram, M.D. (813) 974-2088.

9th Annual Advances in Clinical Medicine, Park Suites Hotel, Orlando. Contact: Michael Kessler, M.D. 1-800-334-6578.

3rd Annual Controversies in Carcinoma of the Breast, March 31-April 2, Marriott World Ctr., Orlando. Contact: Drs. Clark and King (813) 974-2538.

APRIL

Issues in Perinatal Care - 1988, Indigo Lakes Conf. Ctr., Daytona Beach. Contact: Mrs. N. Drane (904) 252-4701.

American Hospitals on Human Values: 1860-1988, April 14-16, Hyatt Hotel, Tampa. Contact: Lois Nixon, Ph.D. (813) 974-3294.

Focus on Education, April 18-20, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Techniques of Eyelid Reconstruction, April 22, Univ. of Miami, Miami. Contact: Larry Garland, M.D. (305) 547-4477.

Coronary Heart Disease: Current Concepts, April 22-23, Sheraton Royal Biscayne, Key Biscayne. Contact: Deborah Wilderson 1-800-421-3756.

5th Annual Magnetic Resonance Imaging 1988, April 24-29, Palace Hotel, Lake Buena Vista. Contact: Dept. of Radiology (873-2090.

MAY

Radiology Review Course '88, University of Miami, Miami. Contact: Carol Lamarre (305) 549-6894.

Current Concepts in Wound Healing and Photography for Cutaneous Surgery, Boca Comm. Hosp., Boca Raton. Contact: Larry Garland, M.D. (305) 547-4477.

9th Annual Child Neurology Postgraduate Course, Sonesta Beach Hotel, Key Biscayne. Contact: Oscar Papazian, M.D. (305) 662-8330, ext. 4822.

Society of Critical Care Medicine, Orlando Marriott, Orlando. Contact: Tracy Schultz (714) 870-5243.

9th Annual Mammoth Mountain Emergency Medicine Ski Conference, March 6-11, Mammoth Lakes, Calif. Contact: Medical Conferences, Inc. 1-800-457-2777.

Cardiovascular and Diabetic Therapy, March 7-9, Good Samaritan Hospital, West Palm Beach.. Contact: Laura Lyons (305) 650-6236.

Wound Dressing/Retinoic Acid March 8, Univ. of Miami, Miami. Contact: Larry D. Garland, M.D., P.O. Box 016960, Miami, FL 33101

2nd Annual Oncology Conference, Peabody Hotel, Orlando. Contact: Wendy J. Henry (305) 897-1600.

Selected Issues in Adolescence, March 11, Harbour Island Hotel, Tampa. Contact: Herbert Pomerance, M.D. (813) 974-4214.

Breast Disease Update & Seminar, March 16-18, The Hilton, Lake Buena Vista. Contact: Esther Cohen, M.D. (305) 674-2311.

Team Management in Patient Care, March 21-22, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Pediatric Goldcoast Conference, March 21-23, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

10th Annual Family Practice Review, March 21-25, Holiday Inn Surfside, Clearwater Beach. Contact: Frances Adams (813) 893-6156.

AIDS: Defining the Process, March 24-26, Building TBA, Daytona Beach. Contact: Halifax Medical Center, Educational Services (904) 254-4169

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socieconomics, governmental, and legal issues as related to medicine.

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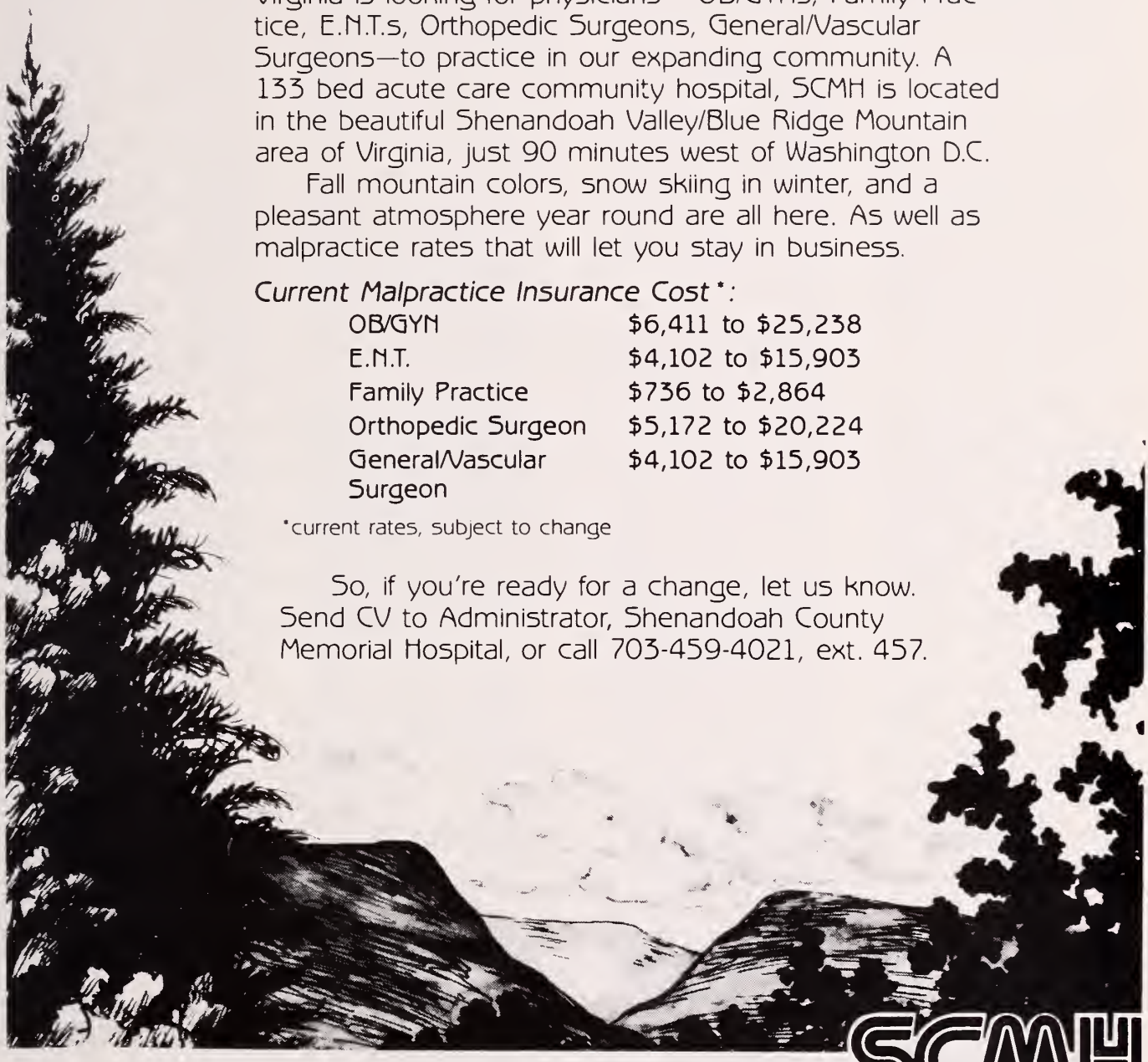
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IMMEDIATE OPENING for BE/BC Radiologist in Central Florida. Florida license required. Must be experienced in all modalities including interventional & MRI. Send CV to R. Nash, M.D., 735 W. SR 434, Suite I, Longwood, FL 32750.

SHENANDOAH VALLEY of Virginia: Shenandoah County Memorial Hospital of Woodstock, Virginia is looking for physicians - OB/GYNs, Family Practice, E.N.T.s, Orthopedic Surgeons, General/Vascular Surgeons - to practice in our expanding community. A 133 bed acute care community hospital, SCMH is located in the beautiful Shenandoah Valley/Blue Ridge Mountain area of Virginia, just 90 minutes west of Washington, D.C. High income potential and LOW Malpractice rates (See our display ad for a complete list of rates). Call the Office of Administration at 703/459-4021, ext. 457, or send CV to: Administrator, Shenandoah County Memorial Hospital, P.O. Box 508, Woodstock, Virginia 22664.

MOLECULAR BIOLOGIST - The Department of Pathology, College of Medicine, University of Florida is seeking a molecular biologist (Ph.D. or M.D.) to fill a tenure-track position at the Assistant Professor level. Research experience in human molecular genetics and cDNA cloning is highly desirable. The successful candidate will be expected to develop and independent research program in human molecular genetics, participate in the educational training of graduate students, and provide technical experttise for the diabetes research center. Applicants should submit curriculum vites, plus copies of three publications which best exemplify their work, and the names of three referees to William J. Riley, M.D., Associate Professor, Department of Pathology, Box J-275, JHMHC, Gainesville, FL 32610. Recruiting deadline is 2/29/88 with approximate starting date of 7/1/88. Salary will be dependent on experience. Equal Employment Opportunity/Affirmative Action Employer.

SURGEON, THORACIC-VASCULAR (no open heart) to join solo practitioner on West Coast of Florida, St. Petersburg, Florida. Please send CV, photo and letter to: Florida Medical Association, Inc., P. O. Box 2411, C-1444, Jacksonville, FL 32203.

EMERGENCY PHYSICIANS: Excellent opportunities available for full-time and part-time physicians on the East Coast, West Coast and Panhandle portions of the state. Hospital volumes vary. Positions offer excellent compensation and malpractice insurance. Respond with C.V. to Karen Block, EMSA, 100 N.W. 70th Avenue, Plantation, FL 33317, or call 1-800-443-3672.

BC/BE FAMILY PRACTITIONER or General Internist. Needed immediately and next year by long established family practice group near Kennedy Space Center. Competitive salary. Early partnership. Large clinic facility and state-of-art local hospital. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1445, Jacksonville, FL 32203.

WANTED SPECIALISTS in the fields of gastroentrology and genentics to evaluate medical records. Send your CV to 118 Olympus Way, Jupiter, FL 33477.

BE/BC family physician needed immediately for busy central Florida solo family practice. Interest im Pediatrics, Gynecology preferred. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1448, Jacksonville, FL 32203.

FAMILY PRACTICE — Great Opportunity to join a busy solo practioner in Lake Worth (West Palm Beach). Board Certification/Eligibility required. Contact Art Altbuch, M.D., 3918 Via Poinciana, Suite 5, Lake Worth, FL 33467, 305-433-1700.

ORTHOPEDIST, BOARD CERTIFIED with Florida license, needed. Ready to retire to non-surgical practice with no investment and immediate income? Our PI/WC group needs you. Florida Regional Diagnostics, Orlando, FL 305-239-0202.

BC/BE FAMILY PRACTITIONER to join six physician department in a 38 member multispecialty group located on eastern Florida's treasure coast. Excellent salary, benefits and growth potential within this progressive organization. Send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1441, Jacksonville, FL 32203.

MEDICAL PRACTICE opportunities available throughout the midwest and western United States. 30 attractive locations to choose from in metropolitan and rural areas. All with excellent salary and benefits. We will match your personal and professional needs with the right practice opportunity. Contact a member of the Health Manpower Placement Program at The Center for Rural Health Services, Policy and Research, 501 Columbia Road; Grand Forks, North Dakota 58201; or call 701-777-3262 collect. We make the intelligent match!

WEST PALM BEACH area, Florida. BC/BE pediatrician to join well established group of 4 pediatricians. Competitive salary and benefits. Dr. Moshe Adler, 1718 North Federal Highway, Lake Worth, FL 33460.

FAMILY PRACTICE: Great opportunity. Join solid group of four FPs in Central Florida. Low malpractice risk area. Abundant patients. Attractive town. Excellent school system. Marvelous place for family. Write: 306 S. Line, Inverness, FL 32652.

PREVENTIVE FAMILY PHYSICIAN to join successful expanding solo practice on Gulf Coast in completely furnished beautiful office. Write: Babiak, M.D., 1872 S. Tamiami Tr. B., Venice, FL 33595.

DERMATOLOGIST, PEDIATRICIAN, ONCOLOGIST, Pathologist, Otorhinolaryngologist, Psychiatrist, Endocrinologist, Orthopedist, General/Family Practitioner. Excellent opportunity for physicians in Los Angeles suburb to join 90 member multispecialty medical group. Large fee-for-service and prepaid practice, no Medi-Cal. Excellent compensation program based on guarantee plus incentive, profit sharing and pension plan. Group provides health, dental, life and malpractice. Partnership in real estate and medical corporation available. Send CV to Wm. Shaw, Associate Administrator, Mullikin Medical Center, 17821 S. Pioneer Blvd., Artesia, CA 90701.

IMMEDIATE OPENING BC/BE clinical adult Neurologist with experience in EEG, EMG & VEP. To join established busy Neurological Group - East Coast of Florida. Competitive Base Salary, incentive benefits with early partnership available. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1442, Jacksonville, FL 32203.

GENERAL SURGEON: Board Certified General Surgeon needed to join expanding 85 Physician multi-specialty medical center in Los Angeles and Orange counties. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1436, Jacksonville, FL 32203.

EMERGENCY MEDICAL GROUP, a progressive, physician-owned organization is seeking Full and Part-time Board certified/eligible and Family Practice physicians for openings in Southeast Florida. Competitive salary, paid malpractice insurance, benefits and attractive scheduling. Send CV to Emergency Medical Group, 1400 NW 12th Ave., Miami, FL 33136.

PRACTICE OPPORTUNITES for family practice or emergency physicians in ambulatory care centers. Competitive hourly fee with ecomonic incentives. Association with hospital E.D. Contact: Robert Schiffer, MRMC, P. O. Box 6000, Ocala, FL 32678. Call (904) 351-7600.

BC/BE INTERNIST to join solo Internist in rapidly growing river community in northeast Florida. Partnership potential in two years. Send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1432, Jacksonville, FL 32203.

GENERAL SURGERY: Opportunities available in CA, OR & WA. Excellent compensation/income potential including salary guarantees and reasonable malpractice rates in communities offering high quality of life. Contact PROSEARCH, 305 NE 102nd Ave, Portland, OR 97220-4199, phone (503) 256-2070.

OB/GYN - California, Central San Joaquin Valley, County Sponsored, Sixteen (16) Physician Multi-Specialty Group Practice with three (3) satellite locations, committed to high quality care, is looking for a board certified/eligible OB/GYN to provide ambulatory, delivery, and surgical services. The position provides a comprehensive benefit package and includes malpractice insurance coverage. Consider a semi-rural lifestyle with cultural amenities and easy access to metropolitan areas, the Sierra Nevada Mountains, and the Pacific Ocean. Salary $98,112 - 103,116 annually. Send CV to: Michael L. MacLean, M.D., Hillman Health Center, 1062 South "K" Street, Tulare, CA 93274, (209) 688-2015. Equal Opportunity Employer.

BUSY INTERNIST, Pompano Beach, FL seeking associate. Leading to full partnership in short period of time. Call collect 305-941-5100.

GENERAL INTERNIST, RHEUMATOLOGIST, NON-INVASIVE CARDIOLOGIST, PEDIATRIC SURGEON, NEUROLOGIST, AND OBSTETRICS & GYNECOLOGY: 40 physician multi-specialty Group in W. Palm Beach, FL seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 2 years. Send CV to Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 N. Olive Ave., W. Palm Beach, FL 33401.

OB/GYN OPPORTUNITES Sunlife OB/GYN Services is a hospital based physician group providing high quality obstetrical and gynecological care. Rapid growth has created career opportunities for OB/GYN trained physicians in Florida, Virginia, and Georgia. We offer excellent compensation, attractive scheduling, career advancement, and procurement of professional liability insurance. To explore these opportunities, please cll Jane Senger USA 1-800-258-9234 or NC 1-800-672-3340.

PHYSICIAN - FL licensed for fast growing walk-in clinic in east central FL. Full-time. Competitive salary in a pleasant town near beaches. Send CV to P.O. Box 16003, Tampa, FL 33687 or call 813-989-1468.

OB/GYN - City on Tennessee state line near Pickwick Lake needs additional OB/GYN to work with two OB/GYNs on staff. Beautiful town near large recreational areas, excellent schools, strong diversified industrial ecomony, temperate climate. Good malpractice insurance situation: generous guarantee and other assistance. Contact Robert Barrett, Magnolia Hospital, Alcorn Drive, Corinth, MS 38834. Phone 601-286-6961, Ext. 107.

NEUROLOGIST for association with established neurology practice serving Tampa Bay Area. Outstanding compensation/benefits. Partnership opportunity. Mail CV ;to P. O. Box 272954, Tampa, FL 33688.

NAPLES, FL, BC/BE Family Practitioner to join progressive fully equipped family practice center. Relocate to the fastest growing area in the entire USA. Family and recreational opportunity's unlimited. Very competitive salary and ownership available. Excellent hours. Reply send CV to Florida Family Care, William Leach, M.D., 1545 CR 951, Naples, FL 33999, 813-455-4104.

FAMILY PHYSICIAN OR INTERIST for association and early partnership or buy out of established active practice on Miami Beach, all hospital privileges, excellent office staff. Please reply to Florida Medical Association, P. O. Box 2411, C-1447, Jacksonville 32204.

FAMILY PRACTITIONER for a progressive rural Florida panhandle community. 50 bed hospital. Office space provided. Attractive contract. One hour from the beach. Good schools. Excellent place to raise a family. Contact administrator, D.J. Hammond 904-263-4431 or send CV to 1305 College Drive, Graceville, FL 32440.

CENTRAL AND COASTAL FLORIDA/NATIONWIDE OPPORTUNITIES Available now for BC/BE physicians also accepting 88 residents. Complete confidentiality, please respond by sending CV or telephone: Frank B. Lane, M.D., Medical Director, MCA, 5121 Ehrlich Road, Suite 107A, Tampa, FL 33624, 813-968-3878.

TIRED OF HMOs? Conduct your specialty or primary care practice in a traditional setting in a growing community south of Ocala. Demand for all specialties exceeds supply (AMA market profile available). The new Mockingbird Hill Professional Center is now open with lease/purchase option. Opportunity now exists for custom interior design. Lab and x-ray on-site and private ambulatory care center provides a referral base. Only 10 min. drive to HCA hospital. For information call or write Carol Roberts, Care-1, Inc., 1805 S.E. Lake Weir Ave., Ocala, FL 32671 or (904) 351-0789.

TEXAS NEEDS DOCTORS. Are you seeking a paved highway to financial success where there is no animosity towards new physicians and low malpractice premiums? Immedicate openings for Family Physician, OB/GYN, Orthopods, Pediatricians, Ophtalmologist, Endocrinologist, Neurosurgeons, and Internists. Send C.V. to Texas Doctors Group, P. O. Box 177, Austin, Texas 78767.

DIAGNOSTIC RADIOLOGIST, immediate opening, Tampa. Board certification, Florida license required. All modalities including magnetic resonance imaging. Attractive benefits, call 813-875-2818.

FLA-ST. PETERSBURG: FL license, BC or BE. Minimum 2 years ER experience. Must have malpractice insurance. $50.00 per hr. Very flexible scheduling. Send C.V. to: P. O. Box 12077, St. Petersburg, FL 33733.

CLINIC DIRECTOR for health department with family practice, patient care & administrative responsibility. Send CV to Director, Collier County Public Health Unit, P. O. Box 428, Naples, FL 33939-0428, 813-774-8210.

OB/GYN OKLAHOMA CITY, large established full service urban hospital currently renovating its OB/GYN services seeking BC/BE obstetricians. Excellent opportunity of establish a practice in an environment with strong administrative and staff support. New medical building connected to hospital. Highly competitive guarantees for salary and office space. Academic appointment available. Send CV, date of availability and references to: Thomas C. Coniglione, M.D., Medical Director, St. Anthony Hospital, P. O. Box 205, Oklahoma City, OK 73102-0205.

FAMILY PRACTICE - BC/BE Casselberry/Altamonte Springs/Orlando area. Office-hospital practice attractive family envirnoment, excellent schools. Strong compensation package. Troy Overstreet, M.D., 120 Sunnytown Road, Casselberry, FL 32707, 305-339-7171.

SITUATIONS WANTED

VASCULAR/GENERAL SURGEON: Board Certified General Surgeon with two-year Vascular Surgery Fellowship. Seeking private practice affiliation with busy group. Florida license; native of South Florida. Available July 1988. Write: P.O. Box 2411, Box C-1411, Jacksonville, FL 32203.

PATHOLOGIST, BOARD ELIGIBLE in Anatomic-Clinical Pathology. Currently doing fellowship in Forensic Pathology in Miami. Primary interest in Forensic Pathology but willing to also do Anatomic-Clinical Pathology. Reply to: 13499 Biscayne Blvd., Box 1008, North Miami, FL 33181.

SELL IT WITH the confidence of receiving top dollar and obtaining the best physician for your patients. Quality and personal attention are our expertise. We can help you now. Call Frank B. Lane, M.D., Medical Director, Medical Consultants of America, at (813) 968-3878. Also private practice opportunities available.

HUSBAND AND WIFE TEAM interested in practicing office GYN and general medicine only. Husband Board Certified and recertified in OB/GYN and presently active in large OB/GYN group practice. Wife actively practicing general medicine, mostly geriatric in Veterans Administration Out Patient Clinic. Both in possession of Florida license. Reply: 2525 13th St. N.W., Canton, Ohio 44708.

FAMILY PRACTICE Board Certified — FL license looking for private practice opportunity (solo, partnership, group) in Orlando. Willing to buy. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1415, Jacksonville, FL 32203.

FLORIDA LICENCED M.D. with 10 years extensive experience as hospital physician seeks full time employment with established HMO/Walk-in Clinic/M.D. Group/or Family Practice, Medical Treatment Center, Health Department/or similar. Available now or by December. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1439, Jacksonville, FL 32203.

B/E INTERNIST, retired, looking for position, association or share office in South Palm Beach County. 305-734-6046.

GENERAL SURGEON, University Trained, Trauma Center experience. Desires position in Coastal area. Solo or HMO preferred. Available July '88. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1446, Jacksonville, FL 32203.

PRACTICES AVAILABLE

ACTIVE, WELL-ESTABLISHED, General Practice with bldg for sale. Gross $180,000 to $200,000 a year. Can be improved. Ideal for minority physician. FL Gold Coast. Write to: Box C-1413, P.O. Box 2411, Jacksonville, FL 32203.

WALK-IN AMBULATORY CENTER for sale. Deal for GP or Internist. Gross $350,000. Full equipment, terms. Miami Lakes - Hialeah. Call Elaine 305-661-6600.

HOLIDAY, FL — Busy growing area. 20 years G.P. Excellent patients, hospitals, area, etc. 130 x 165 lot, 1750 sq. ft. building. 1618 Dixie Highway, Holiday, FL 34690. 942-1624 eves.

SOUTHEAST FLORIDA, fully equipped, outpatient clinic. One doctor grosses over $200,000 annually with Mon.-Fri. 9-5 week. Act now as owner suddenly disabled. Terms. After 7:00 p.m. (305) 428-6226 or (305)/488-6237.

INTERNAL MEDICINE PRACTICE FOR SALE: 80 miles south Disney World, in central Florida. Retiring 28 years. Holter Monitor, Fiberoptics, complete lab, etc. Will introduce. Prefer Cardiologist or gastroenterologist. P.O. Box 2411, C-1418, Jacksonville, FL 32203.

TAKE OVER IM, CVD practice, West Coast Florida. Over thirty years in community. Must be BE or BC. Office midway between two hospitals. Cross coverage available. Will introduce. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1443, Jacksonville, FL 32203.

REAL ESTATE

MEDICAL OFFICE FOR SUB-LEASE in N. Palm Beach (on US Hwy. 1). Fully equipped with laboratory, X-ray, ECG, treadmill, low rent. (305) 627-3130.

MEDICAL OFFICE CONDO for sale. Brand new luxury office, approx. 2,700 sq. ft., fully equiped and designer decorated with mahogany woodwork and state of the art equipment, including IBM 3 terminal computer and Midmark power tables. Located in N. Miami area on Kane Concourse. Perfect for OB/GYN or Surgical practice. The Ultimate in Office Space. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1429, Jacksonville, FL 32203.

FOR SALE: My 5% share of a $6,425,000, large, beautiful and most prestigious professional office building in the Port St. Lucie, FL area. It's 100 yards from the city's only hospital and just next door to a new nursing home. Office rented to ENT. The current buyout price is $92,500. Pictures and floor plan available on request. (305) 283-0912.

LOW MONTHLY RENTAL: Fully improved 1st Floor Medical Suite in established downtown Boca Raton, Fl. Medical/Dental Bldg.-1302 sq. ft. Call: (305) 391-1900.

MEDICAL OFFICE FOR SALE — Jupiter. Adjacent Jupiter Hospital. Fully equipped & decorated. Includes minor O.R. Rental income from parttime tenant covers mortgage. Perfect for new physician or satellite office. $95,000.00. 305-833-0899. Will Finance.

PROPOSED MEDICAL Office/Building — 22,500 square feet of prime real estate in Plantation is available for medical facility. Frontage is on highly traveled State Road 7 and rear faces Plantation Medical Center. owner will accept land lease $30,000 per year or construct build to suit building. Zoning is B-3 and parking is adequate. Land will accommodate 5,000 sq. ft. building or more if 2nd floor is provided. Site improvements are complete. Construction can be handled quickly. For more info. call Jeff Lichterman at (305)/462-5700.

LEASE OR SUB-LEASE Medical Office — 1950 square feet. Prime location North Miami Beach on 163rd Street. Favorable terms—many extras. Call: (305)/945-4181.

SERVICES

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

DISTRIBUTORS, BUYERS, of High Technology Diagnostic Medical Intruments. Holters, Scanners, Ultrasound, EKGs, ICU monitors, Defibrillators, Laboratory Equipment. New or reconditioned. Contact: New Life Systems, Inc., P.O. Box 8767, Coral Springs, FL 33075. Or call (305) 972-4600 or (800) 330-TELL.

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MEETINGS

MEDICAL & PROFESSIONAL BUSINESS MANAGEMENT - Get Smarter & Ski for less! Weekly accredited seminars in Snowmass, Vail & Keystone. LIVE SPEAKER PRESENTATIONS. Complimentary Spouses' Registration. Reduced rate multi-day lift tickets available with pre-registration. Don't chance your tax deduction by enrolling in a video-taped seminar! Call: Resort Seminars, 1-800-542-5428, P.O. Box 5212, Snowmass Village, CO 81615.

1988 CME CRUISE/CONFERENCES ON MEDICOLEGAL ISSUES & RISK MANAGEMENT. Caribbean, Mexico, Alaska, China/Orient, Europe, New England/Canada, Trans Panama Canal, South Pacific. Approved for 24-28 CME Cat. 1 Credits (AMA/PRA) and AAFP prescribed credits. Distinguished lecturers. Excellent group rates on finest ships. Registration limited. Pre-scheduled in compliance with IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, NY 11746. (516) 549-0869.

BIOFEEDBACK THERAPIST Training Workshop — Offering a four day Basic and a four day Advaned workshop for health professionals wishing to provide effective biofeedback therapy. Category I Medical, Psychologica, Nursing & BCIA CEUs available. Basic workshop dates: **1988:** February 4-7, June 16-19, and November 10-13. Advanced workshop dates: **1988:** Jan. 14-17, April 21-24, Sept. 22-25. Two day computer workshop **1988:** March 5 & 6, May 14 & 15, Aug. 27 & 28, Oct. 15 & 16. For brochure contact: Jack Hartje, Ph.D., Biofeedback Therapist Training Institute, 2429 University Blvd. West, Jacksonville, FL 32217. (904) 737-5821.

EQUIPMENT

HOLTER MONITOR: Quality scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretation, scan price $35.00. Recorders loaned, leased or purchase new dual-channel holter recorder, $750.00 with two year warranty. For more information call collect, Advance Medical & Research Center, Inc., (313) 373-1199.

COOPERVISION Natural Eyes. Virtually unused. $7000 or best offer. Contact Sharon Kaste 813-629-7501.

Q B C II Centrifugal Hematology system complete, Clay Adams, 1½ yrs. old. Assume lease. C.S. Quimby, M.D., 2221 59th St. W., Bradenton, FL 34209.

MEDICAL EQUIPMENT for sale: Nonsynchronous Defibrillator-Hewlett Packard; fully Automated/Computerized I.C. Stress Test System, DeVilbiss Pulmonary Function Machine with loop flow capabilities. All excellent condition. Call (813) 197-7566.





11TH ANNUAL MEETING AMERICAN SOCIETY OF NEUROIMAGING

FEBRUARY 11-15, 1988
HARBOUR ISLAND HOTEL
TAMPA, FLORIDA

The 11th Annual Meeting will be held February 13-15, 1988, preceeded by courses in MRI and Neurosonology.

SCHEDULE

Thursday, February 11 (afternoon)
MRI Course

Friday, February 12 (all day)
MRI Course; Neurosonology Course
Evening: Early Bird Reception
Dinner Seminar: Neuroimaging Training: Past and Present

Saturday, February 13
Morning:
MRI Course; Neurosonology Exam
Afternoon:
Symposium I: The Neuroimaging of Infection, Jack O. Greenberg, Director
Evening: Banquet

Sunday, February 14
Morning:
Symposium II: The Changing Nature of Medical Practice, Jack McConnell, Director
Afternoon: Free Communications
Evening: MRI Exam
Dinner Seminar: Neurothermography

Monday, February 15
Morning:
Symposium III: A Mixed Morning of Neuroimaging, Leon D. Prockop, Director
Afternoon: CT Exam

FEES

MEETING 16 Hours Category I Credit		MRI COURSE 16 Hours Category I Credit	
Member	$175	Member	$300
Non-Member	$300	Resident	$ 75
Resident	$ 50	Technician	$150
Technician	$ 75	Certification Exam (Members Only)	$ 75

NEUROSONOLOGY COURSE
8 Hours Cateogory I Credit

Member	$160
Resident	$ 45
Technician	$ 80
Certification Exam (Members Only)	$ 75
CT Certification Exam (Members Only)	$ 75
Dinner Seminar	$ 30

For more information, contact the:

American Society of Neuroimaging
2221 University Avenue, SE, Suite 340
Minneapolis, MN 55414
(612) 378-7290



to STEAMBOAT

For a MEDICAL/DENTAL Seminar

Meetings* are scheduled weekly in Steamboat Springs, from December 19th through April 8th and are approved for AMA, Category 1, AAFP, and AGD.

For information call: 800-525-3402

or write to:
ASSOCIATION FOR CONTINUING EDUCATION
P.O. Box 774168
Steamboat Springs, Colorado 80477

*Programming meets IRS requirements for deductibility if the primary reason for attending is educational/professional.



A WORD TO THE WHYS

WHY AMA? Commitment to maintaining high quality at all levels of medical education is one of the AMA's proudest traditions. The AMA creates policy for medical education, participates in accreditation activities, and supplies the public with information on medical education issues. Proven dedication to high standards in medical education: it's one more good reason why you should be a part of the AMA.

WHY AMA? Now, for the first time there's a forum for hospital medical staffs to meet nationally to discuss common problems and changes in physician-hospital relationships. The Hospital Medical Staff Section was recently created by the AMA to provide leadership in ensuring quality patient care during this period of massive hospital restructuring. It's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.



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